PD-ABN-907 93605

Evaluation of Asia and Near East (ANE) Regional HIV/AIDS Activities

Prepared by:

Peter Godwin, Team Leader Hirokazu Anada Katherine Bond James Fremming Edward Green

Prepared for:

Strategic Planning and Analysis Division
Office of Strategic and Economic Analysis
Bureau for Asia and the Near East
U.S. Agency for International Development

March 1997

Evaluation of Asia and Near East (ANE)
Regional HIV/AIDS Activities
was conducted in Asia under the auspices of the
Strategic Planning and Analysis Division,
Office of Strategic and Economic Analysis,
Bureau for Asia and the Near East.

The Evaluation was conducted by the Health Technical Services Project (Project No. 936-5974.10) of TvT Associates and The Pragma Corporation. The opinions expressed herein are those of the authors and do not necessarily reflect the views of TvT, Pragma, or USAID/ANE Bureau.

Additional copies of this report may be obtained by writing to:

The Health Technical Services Project 1601 N. Kent Street, Suite 1104 Arlington, VA 22209 (703) 516-9166 Fax: (703) 516-9188

or via Internet: hts@htsproject.com

Preface

BUT THE WISE PERCEIVE THINGS ABOUT TO HAPPEN

'For the gods perceive things in the future, ordinary people things in the present, but the wise perceive things about to happen.' Philostratos, "Life of Apollonius of Tyana", viii, 7.

Ordinary mortals know what's happening now, the gods know what the future holds because they alone are totally enlightened. Wise men are aware of future things just about to happen.

Sometimes during moments of intense study their hearing's troubled: the hidden sound of things approaching reaches them, and they listen reverently, while in the street outside the people hear nothing whatsoever.

The Alexandrian poet, Cavafy (1907)

Acknowledgments

The ANE Evaluation Team wishes to acknowledge gratefully the assistance and contributions of those who are genuinely and seriously trying to help the people of Asia respond to the HIV/AIDS epidemic, and who helped the team in their work. An extensive list of contacts appears at the end of this report.

Acronyms

ADB Asian Development Bank

AIDSCAP AIDS Control and Prevention Project

ANE Asia and Near East Bureau

AoA Areas of Affinity

APCASO Asia Pacific Council of AIDS Service Organizations

APEC Asia Pacific Economic Community
ARO Asia Regional Office, AIDSCAP

ASEAN Association of South East Asian Nations

ASEP AIDS Surveillance and Education ASO AIDS Service Organizations ATSP AIDS Technical Support Project

AusAID Australian Agency for International Development AVSC Access to Voluntary and Safe Contraception

CBO Community based organization

CEDPA Centre for Development and Population Activities
CRS Contraceptive Retail Sales Company Pvt. Ltd.

CSO Civil Society Organization
CSW Commercial Sex Worker
DHS Demographic Health Survey
EC European Commission
FHI Family Health International

FPAN Family Planning Association of Nepal FPIA Family Planning International Association

G Global Bureau

GNAP Government National AIDS Programs

GOI Government of India

HAPP HIV/AIDS Prevention Program

HBC Home-based care

HDI Human Development Index HPN Health, Population, Nutrition

IDU Injecting Drug User

IEC Information, Education, Communication

IUD Intrauterine Device

JICA Japanese International Cooperation Agency KAPB Knowledge, attitude, practices, and behavior

MCH Maternal and Child Health MSM Men who have sex with men

NACO National AIDS Control Organization

NCCA National Committee for the Control of AIDS (Laos)

NCDA Nepal Chemists and Druggists Association

NGO Nongovernment Organization NMA Nepal Medical Association

PASA Participating Agencies Services Agreement
PDA Population and Development Association

PNG Papua New Guinea

PPC Policy and Planning Coordination
PSC Personal Services Contractor
PVO Private Voluntary Organization

PWA People with AIDS

RITM Research Institute of Tropical Medicine

RSM Regional Support Mission

SAARC South Asian Association for Regional Cooperation

SDPService delivery pointSTDSexually transmitted diseaseSTISexually transmitted infection

TAF The Asia Foundation

UNAIDS Joint United Nations Program on HIV/AIDS

UNDP United Nations Development Project

UNICEF United Nations Childrens Fund

WFS World Fertility Survey
WHO World Health Organization

Table of Contents

Prefa	ace	iii
	nowledgments	
	onyms	
	cutive Summary	
DACC	divo Sammary	
1. B	ACKGROUND TO THE ANE REGIONAL HIV/AIDS EVALUATION	1
1.1	The ANE Bureau HIV/AIDS Strategic Action Plan 1993-1996	
1.2	The Context of the Strategy	
1.3	The ANE Program: A Summary	
1.4	Evaluation Scope of Work	
1. 1	Diagram Scope of Work	
2. Al	N ASSESSMENT OF THE REGIONAL PROGRAM	7
2.1	Limiting Cross-border Transmission	
2.2	Addressing Regional HIV/AIDS Issues	
2.3	Supporting the Initiation of HIV/AIDS Activities in All ANE Countries	9
2.4	Innovative Pilot Projects	
2.5	Regional Training, Policy, and Research Efforts	
2.6	An Overall Assessment	14
2.7	The Scope and Scale of Interventions: Concerns for the Future	16
2.8	The Nature of ANE Regional Activities	
э т	THE CHANGING REALITY OF THE EPIDEMIC IN THE REGION	10
3. 1. 3.1	The HIV/AIDS Epidemic in Asia	
	HIV/AIDS as a Sexually Transmitted Infection	20
3.2		
3.3	The Context of Sexual Transmission of HIV: Vulnerability	
3.4	The Impact of the Epidemic on Mortality and Morbidity in the Region	
3.5	Issues of Affinity: Regional Issues in the Coming Years	23
4 N	IEEDED RESPONSES AND INTERVENTIONS: LOOKING FORWARD '	27
4.1	Interventions Aimed at Individual Behavior Change	
4.2	Contextualizing Behavior Change	
4.3	Reducing Vulnerability	
4.4	Geographic and Social Mobility	31
4.5	Engaging Civil Society	
4.6	The Role of People Living with HIV/AIDS	32
4.7	New Directions for Social Research to Inform Programming	33

5. PL <i>A</i>	AYERS AND PROGRAMS IN THE REGION	. 3:
5.1	Government Programs	. 35
5.2	Civil Society Responses	
5.3	Other Donors and Organizations	
5.4	Managing the ANE Regional Program	
5.5	Future Management Issues	
5.6	Working in Nonpresence Countries	. 43
6. RE	COMMENDATIONS	. 45
Anne	xes	
Annex	1 ANE Regional HIV/AIDS Activities, FY 1993-1996	
Annex	2 Evaluation Scope of Work	
Annex	3 Field Data Collection Instruments	
Annex	4 Regional Perspectives: A Rationale for Regional Programming	
Annex	5 An Epidemiological Analysis of the Spread of HIV/AIDS in Asia	
Annex	6 The AIDS in the World II Survey of National AIDS Programs	
Annex	7 Indicators for Regional Programming	
Annex	8 A Regional Unit	
Annex	9 Itinerary	
Annex	10 Contact List	

Executive Summary

Background

In November 1992, the USAID Bureau for Asia, the organizational predecessor to the Asia Near East (ANE) Bureau, held a workshop in New Delhi to analyze the HIV/AIDS situation in the region and identify preliminary actions. As a result, the Bureau completed an HIV/AIDS Strategic Action Plan in June of 1993, which has served as guidance for HIV/AIDS interventions in Asia. Utilizing the technical approach of AIDSCAP, USAID's principal HIV/AIDS program, the Plan endorsed the concept of intercountry activities; described priority interventions and methods for selecting the appropriate mix of interventions; and presented a plan for allocation of Bureau resources. The strategy was revised in 1994 to include the North Africa and Middle East regions in its scope, and to broaden the use of Global Bureau cooperating mechanisms to address HIV/AIDS issues and develop innovative responses to the epidemic. To date, these cooperating agencies include the AIDS Control and Prevention Project (AIDSCAP), the International HIV/AIDS Alliance, the National Council for International Health (NCIH) in partnership with the Asia/Pacific Council of AIDS Service Organizations (APCASO), the Centre for Development and Population Activities (CEDPA), and The Asia Foundation (TAF).

Given the worrisome transmission rates in some Asian countries, the apparently important role of cross-border activities in transmission, and the limited knowledge of critical factors in transmission in Asian contexts, it is an opportune time to review the Bureau's strategy for its relevance to current research and developments on the ground, as well as for program results at this relatively early stage of implementation. To respond to these needs, therefore, ANE developed a Scope of Work for an evaluation, of which this report is the primary product. The evaluation's purposes were to:

- Assess what has been achieved based on the original and revised "HIV/AIDS Strategic Plan for Asia" and the annual workplans;
- Evaluate program performance to date and gauge the impacts and the results of the regional HIV/AIDS activities;
- Assess whether the current strategy includes activities and interventions that are best suited to meet the present epidemiological and behavioral pattern of the HIV/AIDS pandemic in light of other donor-assisted activities and prospects for sustainable impact;
- Determine the added value in having a regional HIV/AIDS program in addition to central and bilateral programs;
- Analyze and recommend how regional HIV/AIDS activities can be managed, given the shortages of staff and funding as well as frequent changes in personnel, strategic approaches, and Agency focus; and

 Provide information and forward-thinking ideas that will assist the Bureau in refining its Strategic Plan and in developing a Results Framework for addressing HIV/AIDS for the near-term and long-term (next five to eight years).

Findings

This evaluation has found that activities under this strategy have been basically well-directed toward the objectives. In summary:

- The HIV/AIDS epidemic in many parts of Asia shows a pattern of cross-border transmission by large-scale movements of populations or specific sub-populations. Country programs alone have often proved unable to deal effectively with this. The ANE regional approach has been a powerful response to this pattern.
- Under ATSP II, Thailand, Indonesia and India were priority countries for AIDSCAP. Yet HIV/AIDS epidemics developed quickly in other countries which lacked bilateral AIDS programs, and there was a need to respond. ANE regional funds were able to set the stage for, and help develop, associate country programs. ANE funds were readily available to missions, and were put to use in support of bilateral projects.
- The ATSP/AIDSCAP's "proven interventions" approach was largely set at the project start-up. As the mosaic of regional epidemics began to reveal itself, there was a need for adaptability and flexibility in addressing the changing situation. The ANE regional program could be innovative, responsive, and creative in ways that ATSP/AIDSCAP itself could not. It has helped immeasurably that the AIDSCAP-ANE relationship in Asia has been very good. The Asia Regional Office (ARO) has been a full partner in developing creative responses to the emerging crisis.
- ANE, through its Areas of Affinity (AoA) approach, has been able to address problems in non-presence countries in a limited way. Analysis of the epidemiologic factors discussed in Chapter 3 leads to a prediction of rapid HIV transmission in non-presence countries such as Laos and Vietnam. Another non-presence country, Myanmar, already has one of the worst epidemics in Asia.
- ANE regional approaches in training, policy support, and research have achieved economies of scale, because of the enormous size of the region. This has been particularly important considering the relatively small scale of funding available for HIV/AIDS.
- The ANE regional approaches have helped build consensus and coordinated response among countries. Individual countries cannot deal with HIV/AIDS problems alone, given

the nature of the problem—constant movement of populations across borders and related issues.

• Finally, in the future, there will be fewer bilateral programs, fewer missions and/or fewer officers in missions. It seems there will have to be more regional emphasis, if only by default.

On the strength of these observations, the Evaluation Team concludes that the ANE regional program has been effective as an absolutely critical source of catalytic money and support.

A major Team concern is with the ANE program's scope and the scale on which programs have been implemented. Considering the likely impact of the epidemic on adult morbidity and mortality in the region, resources available for national HIV/AIDS programs are tiny. The kinds of interventions described in the following sections are being implemented on a minute scale; the responses from the private sector are equally small in scale. Most of the interventions currently being undertaken with ANE funding throughout the region are based on proven efficacy, and are, by and large, well designed and implemented. Yet it is the scale of coverage by such interventions that is of greatest concern.

Four questions are of particular relevance:

- To what extent are interventions, whether donor funded, government, or NGO, demonstration or model interventions, designed to stimulate or catalyze their large-scale replication by others, or are they significant contributions to coverage?
- To what extent are interventions limited to prevention, rather than to care and absorption of impact?
- To what extent should interventions be "targeted" at high risk situations, aimed at containing the epidemic, rather than spread across the general population?
- To what extent can interventions, particularly targeted ones, be successfully implemented without adequate policy support? Thus, to what extent does policy support need to be built into intervention based strategies?

Drawing on these lessons, the Evaluation Team feels strongly that an ANE regional program can be most effective as a small, yet absolutely critical, source of catalytic money and support.

- Such efforts must concentrate on developing and demonstrating, or disseminating already developed models which can be replicated by other organizations and donors on the necessary scale.
- The program must develop small-scale, easily-managed and replicated models using catalytic, training, policy, and research activities targeted at critical areas where:

- 1) a maximum effect can be achieved; 2) the need is greatest; 3) the demand is most urgent; and 4) the impact, although indirect, will be coordinated to fill gaps in other organizations' and donors' activities.
- Information must be actively and widely disseminated. If a model is to be developed, how can it be replicated? Who needs to scale it up? If an innovative model activity is funded, how will it be evaluated? How will others learn from it? What kinds of regional dissemination activities will be most effective: presentations at conferences, publications of books and "position" or "best practice" papers, workshops or study tours?
- Programs must continue to stimulate, support, and unite bilateral country programs and essential minimum activities in non-presence countries.

The HIV/AIDS Situation in Asia

There is great diversity and variability regarding what is known about the epidemic in the region. Thailand has by far the best surveillance data, followed by the Philippines. In other countries, surveillance has been poor. Based on what is known or suspected, Thailand, Cambodia, Myanmar, and parts of India seem to have equally advanced epidemics. In Thailand, 2 percent of women in the general population are HIV positive, as measured in antenatal clinics; similar levels are found in parts of India. In Cambodia, some 2.5-3.5 percent of mothers seeking antenatal and family planning services were testing HIV positive in 1995, and this level appears to have been reached more quickly than in Thailand. Indonesia, Philippines, Vietnam and Laos still appear to have relatively low rates of infection. However, Vietnam, and Laos share many transmission factors with mainland southeast Asian countries of relatively high HIV prevalence, and are thus likely to be vulnerable to a major expansion of the epidemic within the next few years. Vietnam is already showing rapid increases of cases among injecting drug users (IDUs) and among young men and women in the south. The lowest infection rates are currently reported in Bangladesh, North and South Korea, Mongolia, and Sri Lanka, but because there is often inadequate surveillance data available, this may indicate very little.

From current data and projections, the epidemic appears to be spreading faster in Asia than in any other part of the world. It is estimated that 4.7 million new HIV infections occurred worldwide in 1995. For the first time, more infections occurred in Asia (2.5 million, or 53% of the world total) than in Africa (1.9 million, or 40%). There has been a leveling off and a decline of cases in Europe and North America. There are some trends of this sort in sub-Saharan Africa, for example, in Uganda and Zambia, but only after infection rates of 20 percent or more in antenatal clinics were reached. Although prevalence rates in Asia are still well below those in Africa, the number of cases in Asia, which contains more than 60 percent of the world's population, are about to exceed those in Sub-Saharan Africa, if they have not already done so. India is estimated to already have some two to five million cases of HIV infection, and the

epidemic is spreading quickly. Were India to reach the same level of HIV infections as Uganda at 21 percent, about 190 million people in India would be infected, the size of Indonesia's entire population, the fourth largest in the world. A strong, prompt, well-targeted response can limit the number of new cases, as Thailand has demonstrated.

The concept of Areas of Affinity (AoA), in terms of concrete geographic and migratory links between countries, was central to the ANE Strategy. This concept has had significant impact on how donors are looking at HIV/AIDS funding. ANE funds have been used successfully in broadening the picture of transmission within the region. This concept can be further broadened, however, to include issues of affinity. Trafficking, migration, and brothel modes of commercial sex work are some concerns that are shared among one or more Asian countries, whether they happen to share borders or not. The Team feels strongly that any regional programming in the future should broaden the intercountry, affinity concept to include attempts to address, as regional, sub-regional or intercountry issues, the wider range of HIV/AIDS-related phenomena found in the region. Working for consensus between countries, addressing issues and problems common to several countries, and helping countries learn and share from each other's experience is an important role for a regional program.

The Evaluation Team therefore recommends:

- 1. The regional programming approach adopted by ANE should be continued. The intercountry/cross-border nature of the epidemic in many parts of the region, and the need to respond flexibly and quickly to the new and rapidly developing epidemic prove that this is an effective response to the epidemic in the region.
- 1.1 The program should be part of a complementary framework within which the strategizing, planning, and programming activities of the HIV/AIDS Division of the Global (G) Bureau, bilateral Missions, and the ANE Bureau can be coordinated and synergized.
- 1.2 Operationally, regional programming should be of a supportive, demonstration, catalytic, analytic, model-building nature, rather than being expected to have an immediate impact on the spread of the epidemic in the region.
- 2. The ANE Regional Strategy should be revised slightly to focus more precisely on strategic functions of a regional, subregional, and intercountry nature. Because of the regional, sub-regional, and intercountry nature of the HIV/AIDS epidemic in Asia/Near East, the tendency for these issues to be minimized in country responses, and the very unequal program response by countries, the strategy and program should be specifically used to:

- 2.1 Develop models for limiting cross-border transmission of HIV within the region.
- 2.2 Facilitate intercountry (regional and subregional) consensus and capacity building with regard to the HIV/AIDS epidemic in the region.
- 2.3 Respond to the spread of the epidemic in the region by supporting and providing technical assistance to HIV/AIDS programs in all ANE countries.
- 2.4 Support and disseminate results from innovative and replicable model projects responding to the changing nature of the epidemic throughout the region.
- 2.5 Support regional training, policy development, and research efforts.

Examples of some indicators which might be used to direct and monitor achievement of these intermediate results (IRs) are given in Annex 7, "Indicators for Regional Programming."

3. ANE should carefully consider the range of epidemiologic and other factors that appear to determine HIV transmission, and the likely impact of the epidemic. This will assist in prioritizing specific initiatives and interventions, both at country level and at intercountry and subregional level. This is necessary both to target interventions appropriately and to identify the most appropriate kinds of interventions for ANE's program.

Four areas deserve special attention:

- 3.1 **Policy and Issues of Affinity**: Achieving a multisectoral response by building consensus with other development mechanisms and addressing on a regional level, including:
 - legal and ethical issues addressing stigmatization and discrimination;
 - health sector issues such as training, access to care, integrated reproductive health services for women, and developing the care sector; and
 - labor and immigration policies relating to prevention and health service access by migrants.
- 3.2 **Nurturing the Response**: Strengthening nascent regional private sector and civil society mechanisms, and coordinating with other regional mechanisms, including UNAIDS, SAARC, ASEAN, WHO, and UNICEF.
- 3.3 **Continuing and expanding support** for targeted interventions, cross-border interventions and interventions for migrants, choices for girls and women, and prevention approaches for adolescents.
- 3.4 Addressing Impact: Developing and/or strengthening social protection systems for families and communities badly affected by the increases in adult mortality and morbidity, strengthening health systems for the increase in costs and burdens, and responding to the needs of those infected.

- 4. Of paramount urgency is the collection and analysis of data in the region, to inform decisions about prioritization, and to determine the cost effectiveness and cost-benefit of initiatives and activities. ANE should collaborate very closely with other players both inside and outside USAID to ensure that this is done. Data need to be collected specifically in these areas:
- 4.1 Social and behavioral sciences, particularly related to sexual behavior, mortality patterns, economic aspects of adult mortality, and migration.
- 4.2 Surveillance (both sentinel and point) of seroprevalence.
- 4.3 Cost-benefit and cost effectiveness of alternative approaches.
- 4.4 Impact assessments in various sectors, particularly health, industry, insurance, and education.
- 5. The intercountry, regional and subregional perspective taken by the ANE regional program highlights the need to adddress the epidemic in nonpresence as well as presence countries. The Evaluation Team recommends that nonpresence waivers are obtained to ensure furtherance of USAID efforts in HIV/AIDS in the region.

Experience from the generally excellent working relationship between ANE and AIDSCAP in the region is that it is cost-effective, strategically appropriate, and locally acceptable to implement the kind of regional program envisaged from within the region rather than from Washington D.C. ANE should be prepared to support the costs of maintaining a regional management unit in the region for coordination and implementation. In addition, there may be similar benefits to be gained from sub-regional implementation in certain geographic areas or around specific themes.

- 5.1 In the short term, ANE should find a way to establish a bridging mechanism for continuing current activities in the region.
- 5.2 In the longer term, ANE needs to establish some kind of management unit within the region whose functions would be to:
 - coordinate the regional program (with missions, ANE, G/W, CAs, contractors, etc.)
 - conduct strategic analyses of regional needs, program design, and priority setting;
 - implement parts of the program (such as policy interventions, strategic analysis, monitoring and evaluation, dissemination, or as default where ongoing activities need to be continued)
 - manage procurements for the regional program (for a range of activities, including technical assistance)
 - liaise with other donors and organizations in the region.

- 5.3 It is strongly recommended that this unit at least facilitates and participates in the overall design of the regional strategy and program.
- The unit should have a minimum of five staff members, both to cover a minimum level of activity under the functions described above, and to produce the synergy of a team.

 Given the limited resources and the nature and extent of the work to be done, staff should include:
 - A leader/coordinator responsible for overall unit functioning, and coordination; and preferably to have primary responsibility for the policy, design, and strategic assessment functions.
 - A quality control specialist, such as a data specialist, epidemiologist, or econometrician who would have primary responsibility for the strategic analysis, monitoring and evaluation, research design, and functions.
 - Two **intervention specialists** responsible for designing, implementing, procuring and managing program activities. These people could be specialists in any of a number of areas (behavior change, public health, community development, etc.); their key skill would be identifying appropriate partners in the region. One individual would have responsibility for the coordination functions.
 - An administrator/accountant responsible for financial and administration logistics, monitoring, and control.
- 5.5 The staff of the management unit should be located in one office in Bangkok.
- 5.6 If there were no regional management unit in the field, ANE could still fund programs that conform to current ANE AIDS Strategy by running some of them through international PVOs and/or UNAIDS.
- 5.7 If one office is not possible, there may be value in having one or two subregional USAID offices, for example, one for the Mekong countries and one for the Indian subcontinent.
- 5.8 A third alternative would be for the HIV/AIDS Division of the G Bureau to strengthen its strategic and operational focus on the ANE Region.
- 6. Countries and missions naturally prioritize national programs and issues. To help stakeholders maximize the benefits they can draw from a regional program, more explicit strategic objectives and indicators of program success, reflecting both the functional as well as the substantive nature of the program, should be developed in conjunction with missions and the G Bureau. ANE should explore mechanisms for shared accountability for the strategic objectives and indicators.

L.

7. In strategizing and programming for the region, ANE should seek to work with a variety of players. It should: 1) coordinate closely with other major donors, particularly UNAIDS, AusAID, JICA and the EC; 2) use the wide range of NGOs and PVOs with experience and capability in the region; and 3) tap the efforts of emerging regional and subregional networks of private sector members responding to the epidemic. Specific responsibility for this should be part of regional implementation.

1. BACKGROUND TO THE ANE REGIONAL HIV/AIDS EVALUATION

1.1 The HIV/AIDS Strategic Action Plan

By the early 1990s, the ANE Bureau had recognized that HIV had arrived in Asia, that it was rapidly spreading, and that a coherent regional response was required. In November of 1992, the Bureau for Asia (an organizational precursor of ANE) held a workshop in New Delhi to analyze the situation in the region and identify preliminary actions. As a result, a survey of Missions was conducted to gather further information on the status of the epidemic and levels and types of related USAID activity in each country. The survey found substantial variation in rates of HIV infection, notable discrepancies in quality of surveillance and sexual behavior information, and varying levels of government and international donor commitment to responding to the epidemic.

Based on this newly collected information, and Agency knowledge from several years' experience with the epidemic, the Bureau completed an HIV/AIDS Strategic Action Plan in June of 1993. This has served as guidance for HIV/AIDS interventions in Asia.¹ Utilizing the technical approach of AIDSCAP, USAID's principal HIV/AIDS project, the Strategic Plan 1) endorsed the concept of Areas of Affinity (AoA) in Asia; 2) described priority interventions and methods for selecting the appropriate mix of interventions; and 3) presented a plan for allocation of Bureau resources. In recognition that the epidemic was both regional and country-specific in epidemiology and opportunities for response, the Plan was developed as a guide for all Bureau HIV/AIDS activities, whether bilaterally implemented or centrally funded. ANE has used this plan as the basis for reviewing all new program proposals and monitoring results of interventions in the region.

In subsequent refinements, ANE has identified the **objectives** of the regional strategy. These include:

- Limiting cross-border HIV transmission
- Addressing regional AIDS issues
- Supporting the initiation of HIV prevention programming in all ANE countries
- Supporting innovative pilot projects which may be replicated throughout the region
- Supporting regional training, policy, advocacy, and research efforts.

¹ The Strategic Action Plan, and this evaluation as well, include in their scope only Asian countries (the Indian subcontinent eastward to the Philippines). Since 1994, country coverage of ANE has additionally included North Africa and the Middle East (Morocco eastward to Jordan). While the Bureau currently has no strategic plan for HIV/AIDS activities in this area, a subregional approach, suitable to conditions of the epidemic in North Africa and the Middle East, is under consideration by the Bureau.

The strategy was revised in 1994 to include the North Africa and Middle East regions in its scope, and to broaden the use of Global Bureau cooperating mechanisms to address HIV/AIDS issues and to develop innovative responses to the epidemic. To date, these cooperating agencies include the AIDS Control and Prevention Project (AIDSCAP), the International HIV/AIDS Alliance, the National Council for International Health (NCIH) in partnership with the Asia/Pacific Council of AIDS Service Organizations (APCASO), the Centre for Development and Population Activities (CEDPA), and The Asia Foundation (TAF).

The strategy also includes a guiding rationale for a separate strategic plan for HIV/AIDS interventions in Asia, highlighting eight points:

- **Population**: The sheer size of many country populations in the region carries weighty implications for providing effective and adequately targeted assistance to vulnerable groups. Continued expansion of the epidemic will call for specialized policy work to build momentum among national governments and international donors for meeting procurement burdens.
- **Urbanization**: Asian road systems are generally well developed and economies are not markedly segmented into urban and rural sectors. Migration between city and countryside may be expected to add intensity and complexity to transmission patterns.
- Rapid economic development: Economic growth throughout much of Asia has led to
 huge shifts of population within and among countries as populations search for work.
 These populations, often single and away from their families with disposable income, are
 more prone to engage in high risk behavior due to peer pressure and weakening of
 traditional behavioral norms.
- **Double standards of sexual conduct**: Premarital and extramarital chastity is traditionally important in many areas of Asia, but this tends not to be so strongly held for men. In Asia one manifestation of this double standard is the presence of a substantial commercial sex industry. Commercial sex workers often become reservoirs of STIs, including HIV.
- **High levels of education**: Some countries in the region, particularly in Southeast Asia, have high literacy and education rates. Among young people in some countries, literacy approaches 100 percent. This means that HIV/AIDS-related communication strategies that utilize the printed word may be effective in some areas, and that young people can often be reached in school settings to receive risk prevention messages.

- **Developed health and family planning infrastructures**: Condom distribution and STI screening may utilize well developed family planning structures in many countries. Also, public and private health care systems are extensive in some areas.
- **Prevalence of STIs**: Further research is needed on prevalence rates for various STIs in Asia, but the general supportive relationship of STIs to HIV infection is well documented.
- Apparent recent arrival of the HIV epidemic in Asia: While some countries, such as India and Thailand, have displayed rapid expansions of HIV prevalence, other Asian countries have not. The relative newness of the epidemic in Asia, and weaknesses in surveillance systems may account for such disparities, although other factors may be at work. The ANE strategy should promote policy dialogue to support national responses on a timely basis.

All of these factors continue to be relevant to the 1996 epidemic in Asia. This evaluation shows, however, that in many instances the interpretation of these factors needs to be updated and refined in light of more recent research and experience in the field.

1.2 The Context of the Strategy

The Asia region represents the fastest growing HIV/AIDS epidemic in the world. More new infections per year are currently taking place in Asia than in Sub-Saharan Africa. The absolute number of infected individuals is expected to far exceed that of Africa, due to the much larger overall Asian populations.

Given the worrisome transmission rates in some Asian countries, the apparently important role of cross-border activities in transmission, and the still limited knowledge of critical factors in transmission in Asian contexts, it is an opportune time to review the ANE Strategy for its relevance to current research and developments on the ground, as well as for program results at this still relatively early stage of implementation.

In addition, as the Agency continues its plans to phase down activities and staff presence worldwide, a review of the strategy offers an opportunity to consider various alternative mechanisms and management arrangements for carrying out the strategy. The closeout of the Regional Support Mission in Bangkok in 1996, the planned completion of AIDSCAP in 1997, and commencement of a revised Global Bureau HIV/AIDS strategy in 1997 combine to create a new Agency environment for the ANE strategy.

1.3 The ANE Program: A Summary

The current ANE HIV/AIDS Strategy features three specific components:

Regional Activities

• Training activities and sharing of data, expertise, materials, and resources across the region.

Areas of Affinity (AoA)

• Behavioral and epidemiological research and pilot interventions implemented within defined clusters of countries which address cross-border transmission issues.

Country Specific Activities

• Behavioral and epidemiological pilot prevention activities with potential for regional replication.

Chapter Two of this report offers a discussion and assessment of the field programs built around these components; further information on particular activities is provided in Annex 1. The total funding level from ANE for HIV/AIDS regional activities for FY 1993-1995 is approximately US\$ 7.5 million.

1.4 Evaluation Scope of Work

To respond to the need for a review of the regional HIV/AIDS program, ANE developed a scope of work for an evaluation, of which this report is the primary product. The evaluation's purposes were to:

- Assess what has been achieved based on the original and revised "HIV/AIDS Strategic Plan for Asia" and the annual workplans;
- Evaluate program performance to date and gauge the impacts and the results of regional HIV/AIDS activities;
- Assess whether the current strategy includes activities and interventions that are best suited to meet the present epidemiological and behavioral pattern of the HIV/AIDS pandemic;
- Examine other donor-assisted activities and prospects for sustainable impact;

- Determine the added value in having a regional HIV/AIDS program in addition to central and bilateral programs;
- Analyze and recommend how the regional HIV/AIDS activities can be managed, given the shortages of staff and funding and frequent changes in personnel, strategic approaches, and Agency focus; and
- Provide information and forward-thinking ideas that will assist the Bureau in refining its Strategic Plan and in developing a Results Framework for addressing HIV/AIDS for the near term and long term (next five to eight years).

Twenty-one evaluation questions also guided the review, grouped under the following categories:

- Achievement of Goals
- Impacts and Results
- Technical Soundness of Strategy/Approach
- Management Issues
- Future Directions

Data collection included: 1) desk review of existing data and documentation; 2) interviews with knowledgeable staff of USAID/ANE, G, missions, cooperating agencies, other donors, country governments, and clients/beneficiaries; and 3) site visits in Bangladesh, Cambodia, India, Indonesia, Laos, Nepal, the Philippines, Thailand, and the United Kingdom (home of the HIV/AIDS Alliance). Field data collection in Asia covered a period of approximately three weeks in September and October of 1996.

For the reader's reference, the SOW is provided in Annex 2.

2. AN ASSESSMENT OF THE REGIONAL PROGRAM

In this Chapter, each of the five objectives of the ANE Regional Program is reviewed, with examples from the field. A sixth section presents an overall assessment. Two final sections contain areas of concern for the future.

2.1 Limiting Cross-border Transmission

The Areas of Affinity (AoA) aspect of the ANE strategy continues to be one of the most important ANE contributions to limiting cross-border transmission. For example:

► The Thai-Cambodia border assessment funded by ANE brought significant attention to the need for cross-border programs. The sites studied are now integrated into an initiative sponsored by UNAIDS which brings provincial officials and higher level policy decision makers together to develop a cross-border strategy.

Working Across the Border at Raxaul and Birganj

The two program managers whose projects meet and interact at the Nepal/India border identify seven benefits from this collaboration:

- shared advocacy
- shared social and political mobilization at the border
- shared training
- complementarity of services (one does STD treatment, the other outreach).
- shared materials
- maximizing coverage of a single situation
- counter-balancing each other's strengths and weaknesses, successes, and failures.

A further benefit could well be shared data collection and analysis.

- The highway network linking India, Bangladesh and Nepal is a major potential source of risk for the three countries. HIV levels among truck drivers in India are about 10 percent. AoA activities on the India/Nepal border, and related workshops in Calcutta, have greatly heightened recognition of this problem.
- ► Training components designed to respond to the Areas of Affinity concepts are contributing to increased understanding, skills, and strategic thinking among Lao officials on the National Committee for the Control of AIDS (NCCA) and members of other important bodies. A project with CARE has activated district HIV/AIDS committees in areas with high cross-border activity on the Thai/Laos border. Information, education, and communication (IEC) materials are currently undergoing pretesting by target groups in each area by members of the provincial AIDS committees.
- ▶ In the Philippines and Indonesia, mechanisms are in place to conduct AoA cross-border interventions through PVO implementing agencies such as PATH. While the AoA concept was used to develop model interventions in each country, bilateral projects developed have become purely country programs. Continued support to further encourage the intercountry linkages is required.

Developing Responses in Laos with ANE Funds

Laos is a nonpresence country with few resources and little activity related to HIV/AIDS prevention. ANE funds have had a special value here, and are placed with an agency that understands and has developed long-term relations with the Lao authorities.

The Areas of Affinity (AoA) approach has been important, not only in targeting populations that cross borders, but also in strengthening the Lao provincial AIDS committees in those towns. Cross-border visits and trainings by Lao have improved the local response.

The director of the Huay Xai hospital participated in a training in Chiang Khong province, directly across the border in Chiang Rai Province, Thailand. The training included PWAs and discussed issues of care. When the doctor returned, he visited a patient several times and encouraged him to check into the hospital for treatment. In contrast, an HIV patient had a relative who was a doctor in the district hospital in Pakse Province (in the South), but was declined treatment.

Study tours and trainings in Bangkok were useful in increasing understanding and stimulating thought among AIDS workers in Laos. Participants involved in the CARE project have been able to apply some lessons from the training to their current work. Dr. Chantone, a member of the National Committee for the Control of AIDS, suggested, however, that opportunities also be made to visit countries with similar policies, for example on prostitution, such as Vietnam. The training for journalists in Nong Khai Province, Thailand, was also useful, though all published materials must pass the Ministry of Information and Culture. Future trainings should include MIC representatives.

The AoA concept seems to have been adopted by the European Community (EC), which is considering supporting projects which "twin" border sites. This might include a project on the Vietnam border with booming local markets, and thus high localized vulnerability to infection.

Cross-border Issues of Concern in Bangladesh

Prof Nasrul Islam, head of the Bangladesh National AIDS Program, identifies four areas of cross border concern:

- ► Transportation routes from India into Bangladesh (and planned for expansion across Bangladesh, to link West Bengal state with the northeastern states); Trucks stop at several points along this route, noticeably at a ferry within Bangladesh—waiting periods for trucks may be several days.
- ► Transient CSWs moving and plying between Calcutta and Dhaka and Chittagong (and points in between).
- ▶ The ethnic people of Manipur who live on either side of the border between India and north eastern Bangladesh; HIV rates among them, on the Indian side, are among the highest in India.
- ▶ Sailors, based in Chittagong and other Bangladesh ports, who regularly travel back and forth across the Bay of Bengal between Myanmar, Thailand, India and Bangladesh.

This analysis has helped the Mission identify suitable possible support within its country strategy, drawing on ANE-funded technical assistance.

2.2 Addressing Regional HIV/AIDS Issues

The ANE regional mechanisms have been extremely useful in helping respond to the developing nature of the epidemic in Asia. For example, in the early stages of the epidemic in the region, Laos and Cambodia benefitted significantly from the technical assistance and training supported by ANE, and exposure to programs in Thailand. Each of these countries still faces tremendous challenges in developing national responses and infrastructures to deal with the prevention and care needs they

Thai Fishermen in Irian Jaya

Between 1993-96, ANE supported a PATH implemented study of HIV transmission from Thai fishermen to women in Irian Jaya. It appears that the people of Irian Jaya are at special risk of HIV infection, due to a combination of epidemiologic factors discussed in Chapter Three. Ninety out of 410 known HIV/AIDS cases in Indonesia come from Irian Jaya, a contribution far disproportionate to the population of that half-island. Sixty-seven of the 90 cases are Thais. Dealing with the spread of HIV in Irian Jaya, whether from Thai fishermen or from across the border from Papua New Guinea, is clearly important for Indonesia's HIV program. ANE funding to identify and investigate these kinds of cross-border issues was critical: particularly as Irian Jaya is not a priority in the Indonesian national program, nor covered under the USAIDsponsored HIV/AIDS Prevention Project.

will face in the next decade. Continued regional programming will have considerable impact in the sub-region of mainland Southeast Asia, given the current state of the epidemic, socioeconomic and epidemiological risk factors, and extent of in-country and cross-border migration.

Country programs in Indonesia and the Philippines are more developed than in other Asian countries. The potential spread of HIV appears to be slower and less extensive there as well. Strategies currently could be shared with other countries with similar problems. Areas where continued AoA support may have an impact are the Irian-Jaya, PNG, and Torres Straights area, and cross-border programming with Indonesian and Filipino seafarers.

STI syndromic management and treatment modules adapted to suit local needs from the original WHO modules have been developed for many countries with ANE support. The behavioral sentinel surveillance model has been adopted by country programs in Cambodia, Philippines, India, Nepal, and Indonesia.

2.3 Supporting the Initiation of HIV/AIDS Activities in All ANE Countries

ANE funds have been used successfully in South and Southeast Asia to catalyze or support the establishment of bilateral country programs in missions with no previous activities.

Cambodia

Cambodia has no bilateral HIV/AIDS program but has benefited substantially from ANE support. In 1995, ANE funds were used to support a strategic assessment on HIV and STI surveillance, HIV testing and counseling, and to develop plans for behavioral surveillance. As a result, a sound syndromic management treatment program has begun, based on revisions made to the WHO guidelines. ANE also helped to establish that *n. gonorrhea* had developed resistance to three commonly used antibiotics, resulting in recommendations for appropriate substitution. ANE funds were available quickly and put to immediate use.

Key members of the National AIDS Committee participated in ANE-supported regional training, increasing their ability to identify problems and to learn from successful strategies in neighboring countries.

Based on an ANE-supported study of cross-border migration between Thailand and Cambodia, UNAIDS has held meetings with relevant officials on both sides of the border to develop policy guidelines and determine intervention activities.

- Philippines, and Indonesia all have bilateral HIV/AIDS programs. Cambodia is in the process of establishing one. Technical assistance from AIDSCAP (through the AIDSCAP Regional Office in Bangkok, and with ANE regional funding) and the availability of ANE "start-up" resources have played a major part in ensuring the high quality design of these projects.
- ► Initial assessments of the need for HIV/AIDS programs have been conducted in Cambodia, India, Indonesia, Morocco, Nepal, Egypt, Mongolia, and Sri Lanka.

Developing an IEC Strategy in Indonesia

ANE funds were used to develop the Ministry of Health's IEC strategy, using a locally-hired consultant with the PKM project. This three-tiered strategy, which was developed for six groups—sex workers, journalists, truck-drivers, prisoners, NGOs, and fishermen—produced materials for target group members, opinion leaders, and gate-keepers, including health providers and decision makers. In addition to developing training manuals, a series of games, posters, and stickers was produced and is now being requested by other ministries, the army, and other donors, which report great popularity of these tools. A directory and data base of AIDS research in Indonesia was also produced. It has been distributed throughout 27 provinces, and is considered of particular use to researchers.

Jump-starting an HIV/AIDS Program in Nepal

By 1993 the Mission realized that Nepal was facing a serious threat from the epidemic. No resources were allocated for this, however, at that time. Using ANE funds, the Mission called upon AIDSCAP to assess the situation. The "Sexual Networking in Five Urban Areas in the Nepal Terai" report formed the basis for a strategic plan and the current program, financed 36% with ANE funds (for the AoA portion) and the rest by the mission bilaterally.

The program has developed an extensive strategic network of local NGOs to implement activities. General Welfare Pratisthan (GWP) implements outreach activities aimed at high risk situations along 435 km of the main highway from Kathmandu to India, through which 80% of Nepal's imports travel. LALS (Lifesaving and Lifegiving Society) provides TA and training to GWP, and develops peer education materials. The Nepal Medical Association (NMA) and the Nepal Chemists and Druggist Association (NCDA) have developed STD management packages for syndromic treatment; the Family Planning Association of Nepal (FPAN) is integrating STD treatment into its clinics along the highway, while Contraceptive Retail Sales Company (CRS) provides social marketing of condoms. New Era, a research institute, conducts baseline, monitoring and evaluation surveys, and Stimulus (a local advertising firm) designs and provides media support.

Linking the bilateral project to the AoA activity has demonstrated the synergy that can be achieved under a regional program.

2.4 Innovative Pilot Projects

The development of pilot projects and innovative programs for replication and dissemination have been a mixed success. Where these have been carefully designed, with the appropriate monitoring and dissemination features built in, they have been (or will be) very useful; some, however, have been more ad hoc, guided more by local considerations than by coherence within the overall regional strategy.

Working with Islamic Leaders in Indonesia

ANE funds sponsored a study of Islamic leaders by the Center for Health Research Development at the University of Indonesia. The study opened up a dialogue of the role of Islamic leaders in responding to HIV/AIDS with government policy makers and health officials. A workshop, supported by ANE and UNICEF, resulted in the Badung Declaration (Nov. 1995), in which the leaders stated their recognition of the AIDS problem and addressed the need not to discriminate unfairly against PWAs, the need to reinforce family resilience and religious values, and the need for Islamic leaders to contribute to HIV/AIDS prevention as part of their religious practice. Islamic leaders at this and other forums have stated their willingness to promote AIDS and STD prevention through an approach based on traditional Islamic values such as chastity or purity, fidelity within marriage, and respect for the body through avoidance of alcohol and drugs.

Women, the Family and AIDS Prevention

In July 1995, ANE, with the Ford Foundation and UNFPA, supported a three-day workshop, hosted by Chiang Mai University's Women's Studies Center. Participants from the Mekong subregion discussed and observed HIV prevention strategies focussing on women and the family. Papers ranged from analyses of gender-power relations in HIV transmission, prevention and care to studies from Thailand, Yunnan Province of China, Vietnam, Laos and Cambodia. Participants also visited innovative projects for CSWs, hilltribe women, and people with HIV/AIDS in the Chiang Mai area. A follow-up action plan recommended training programs, multisectoral networking, dissemination of model project results, and development of cooperation between borders in controlling trafficking and providing health care services.

CEDPA in Nepal

Beginning in FY 1995, CEDPA became a partner in USAID/Nepal's HIV/AIDS program. CEDPA's experience is in promoting women's reproductive health and well being. As the lead implementing organization for the G/PHN/POP, Access to Family Planning Through Women Managers (ACCESS) Projects' contribution to the Mission's HIV/AIDS efforts has been to integrate STD/HIV/AIDS education into local NGO and women's network activities. Features of CEDPA's activity include:

- ▶ Work with indigenous NGOs and AIDSCAP partners to organize and support Nepal's first national "Condom Day" to catalyze public awareness of condoms for both family planning and HIV/AIDS prevention. The theme was responsible fatherhood, highlighting men's roles in reproductive and sexual behavior. This communication effort reached an estimated 50,000 Nepalis at a cost under \$3,000.
- ► Exploration of alternative methods of communicating prevention awareness including offering leadership roles in prevention discussion groups to males, seeking opportunities for one-to-one communication, and using leaders of informal local networks as critical actors in the planning and execution of IEC-related events.

The International HIV/AIDS Alliance

The International HIV/AIDS
Alliance has established programs
supporting 237 NGOs in seven
countries—four of them in the
ANE region. With ANE funding, it
has started programs in Sri Lanka
and Morocco. The Alliance has
been an important player in the
ANE strategy because of its
particular approach:

- as an international organization, it builds networks of NGOs and CBOs, and is a funding channel to them;
- it helps establish a wide range of grassroots responses to the epidemic, based on careful assessments of local needs;
- it helps NGOs broaden and expand their responses;
- it encourages policy dialogue for energizing the NGO/CBO sector.

The Alliance's practical, technical high quality and focused approach, makes it a good partner for the regional program.

An important set of activities has resulted from an initial attempt in the last year to broaden the range of activities beyond the traditional AIDSCAP program. Examples of these activities include: 1) integrating HIV/AIDS into women's empowerment and family planning programs, through the CEDPA ACCESS project in Nepal; 2) extending capacity-building in the NGO sectors of several countries through the HIV/AIDS Alliance; and 3) addressing issues of trafficking of women² through The Asia Foundation's Women in Politics program. Some of these activities are in the planning stages. All need more time to show results.

The examples highlighted above describe well designed activities. Some, however, have been more *ad hoc*, guided more by local considerations than by coherence within the overall regional strategy.

The Asia Foundation: Trafficking and HIV

The Asia Foundation provided support through its Women in Politics Program to organize and facilitate the Regional Dialogue on Trafficking and HIV/AIDS in Kathmandu, August 19-23, 1996. The dialogue included experts from the governmental and nongovernmental sectors, and was organized to encourage expanded dialogue on the problems of trafficking and HIV/AIDS, promote national and regional collaboration between government and other sectors, and strengthen advocacy capacity in these areas.

A total of 25 individuals participated in the dialogue as participants, resource persons and observers. Participants were from eight countries (Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines, Sri Lanka and Thailand). Through advocacy, coordination and monitoring efforts in each country, national efforts and regional efforts to reduce trafficking are expected to be strengthened. Priority short-term actions agreed upon include:

- Development and expansion of a core resource network including organizations, facilities and persons;
- Review of the adequacy of national laws and applicable human rights instruments, including compliance and enforcement; and
- Organization of meetings to address intercountry trafficking issues, such as those in Cambodia/Thailand/Myanmar/Laos, India/Nepal/Pakistan/Bangladesh, and Malaysia/Indonesia/Philippines/Singapore/Hong Kong/Taiwan/Japan.

Longer-term objectives include further capacity building among organizations concerned with trafficking, and encouragement of comparative research on trafficking and correlated issues.

This is an important area for the strategy to expand into, as it opens up a complex and critical set of issues relating to various kinds of trafficking (not just women), as well as a number of gender issues (not just trafficked women).

2.5 Regional Training, Policy, and Research Efforts

ANE funds have supported regional training programs in the areas of policy, epidemiology, training of trainers, communication on sexual behavior, and communication for journalists. These training programs have had mixed results.

Development of programs and study tours have enabled a broad range of people in the region to gain exposure to new methods, ideas, and strategies in IEC development and epidemiology. The informal exchanges that took place during these visits were valued as much as

the formal training. However, while

state-of-the-art, the participants felt

the communications curricula developed was regarded as

The Indonesia Policy Study Tours

Four groups of key policy makers from Indonesia visited Thailand to learn about policy responses to HIV/AIDS and specific HIV/AIDS program strategies. Hosted by the Institute for Population and Social Research, Mahidol University, they met with senior policy makers, the military, and other officials, as well as groups of people with HIV/AIDS. As a result, a working group on AIDS, comprised of Indonesians who participated in the study tours, convened to develop the Indonesian National Strategy on HIV/AIDS. The strategy contains three components felt to be critical to the Indonesian setting: religious and cultural responses, family and economic resilience, and public health responses.

the time frame for training was too short. ANE funds have also been used to support networks of alumni in each country to try to ensure long-term follow-up.

Epidemiologic Roundtable in India

In 1993 the first projections of the epidemic in India, made by NACO (the National AIDS Control Organization), suggested the likely size of the epidemic over the next decade. Unfortunately, these projections ran into political resistance. In 1994 a visit by Dr James Chin failed to resolve the issue. By 1996 the lack of data, and/or the lack of use of data to make projections, was finally recognized as serious.

With ANE funding, the AIDSCAP Regional Office convened an Epidemiologic Roundtable in India, in August 1996. This event brought together epidemiologists from all over India, with experts from Thailand and Kenya, to discuss the state of surveillance in India, and has been considered a major step forward.

Through policy study tours, direct technical assistance, and regional trainings, the HIV/AIDS
Prevention Project in Indonesia was developed, and interest is high in developing a bilateral program in Cambodia.

2.6 An Overall Assessment

This Evaluation Team has found that activities under this strategy have been basically well directed toward the objectives. In summary:

► The HIV/AIDS epidemic in

many parts of Asia shows a pattern of cross-border transmission by large-scale movements of populations (or specific subpopulations). Country programs alone have often proved unable to

deal effectively with this. The ANE regional approach has been a powerful response to this pattern.

- ▶ Under ATSP II, Thailand, Indonesia, and India were priority countries for AIDSCAP. Yet HIV/AIDS epidemics developed quickly in other countries which lacked bilateral AIDS programs, and there was a need to respond. ANE regional funds were able to set the stage for and help develop Associate Country programs. ANE funds were readily available to missions, and were used in support of bilateral projects.
- ▶ ATSP/AIDSCAP's "proven interventions" approach was largely set at the project start up. As the mosaic of regional epidemics began to reveal itself, there was a need for adaptability and flexibility in addressing the changing situation. The ANE regional program could be innovative, responsive, and creative in ways that ATSP/AIDSCAP itself could not. It has helped immeasurably that the AIDSCAP-ANE relationship in Asia has been very good. The ARO has been a full partner in developing creative responses to the emerging crisis.
- ▶ ANE, through its AoA approach, has been able to address problems in nonpresence countries in a limited way. Analysis of the epidemiologic factors discussed in Chapter 3 leads to a prediction of rapid HIV transmission in nonpresence countries such as Laos and Vietnam. Another nonpresence country, Myanmar, already has one of the worst epidemics in Asia.
- ▶ ANE regional approaches in training, policy support, and research have achieved economies of scale, due to the enormous size of the region. This has been particularly important considering the relatively small scale of funding available for HIV/AIDS.
- ANE regional approaches have helped build consensus and coordinated responses among countries. Individual countries cannot deal with HIV/AIDS problems alone, given the constant movement of populations across borders and related issues.
- Finally, in the future, there will be fewer bilateral programs, fewer missions and/or fewer officers in missions. For these reasons, there will have to be more regional emphasis, if only by default.³

On the strength of these observations, the Evaluation Team concludes that the ANE regional program has been effective as an absolutely critical source of catalytic money and support.

The only other bilateral donor found implementing an AoA program in S.E. Asia, was AusAID, which supports a Thailand/Myanmar cross-border initiative. This program is implemented through World Vision/Australia. AusAID funds are used for preventive education, condom provision, and treatment referral on the Thai side of the border; World Vision uses its own funds for similar interventions on the Burmese side.

2.7 The Scope and Scale of Interventions: Concerns for the Future

One of the most important lessons for Asia to learn from the experience of Africa and the West, is the futility of trying to deal with the HIV/AIDS epidemic simply as an outbreak of a sexually transmitted infection. The intimate human manner of transmission and the cultural and social environment surrounding attention to and discourse about this, the extent to which it is spreading, and the devastating implications of infection, accord HIV/AIDS special attention. It is essential that the wide range of gender and economic vulnerabilities that both lead to the spread of infection, and result from it, are addressed. Thus, to be effective, programs responding to HIV/AIDS must be mounted on a scale unlike most other public health programs. This scale is comparable to population and family planning programs over the last thirty years, and must incorporate the same kind of sustained policy and socioeconomic dialogue to ensure an enabling environment.

A major concern that the Team had about the ANE program was with the scope and scale on which programs have been implemented. Considering the likely impact of the epidemic on adult morbidity and mortality in the region⁴, resources available for national HIV/AIDS programs are tiny. The kinds of interventions described in the previous sections are being implemented on a minute scale. The responses from the private sector are equally small in scale. Most of the interventions currently being undertaken with ANE funding throughout the region are based on proven efficacy, and are, by and large, well designed and implemented. Yet it is the scale of coverage by such interventions that is of greatest concern.

Four issues are of particular relevance:

- To what extent are activities demonstration or model interventions designed to stimulate or catalyze large scale replication by others? Or are they significant contributions to coverage? While in practice there may not appear to be much to be gained from this distinction, strategically it is vitally important, because of the monitoring and evaluation and dissemination elements that need to be added. This question needs to be asked of the Nepal and Madras USAID projects, for example. The APAC (Tamil Nadu) project document suggests that the project will cover three million people. With what is known about STI rates in the state, the project appears to be designed to provide most of the STI coverage. Yet this is not at all the position as described by the project staff in Madras, who suggest that they are only providing a small part of a much fuller service from the Government.
- To what extent are interventions limited to prevention, rather than to care and absorption of impact? It is now clear that attention in areas where the epidemic is becoming mature is rapidly shifting towards care issues; but at the same time, models of "care" far beyond simple treatment of AIDS cases are being developed. They are made up of a variety of

Calculations from Africa (see National Research Council, op.cit) suggest that an HIV prevalence of 5% increases prime age (15-50) adult deaths by 50-100%; a 20% prevalence increases deaths 3-5 fold.

elements including self-help, home-based care (HBC), psycho-social support, counseling, and community involvement. Where large numbers of infections already exist in the general population, are marginal resources best used in prevention activities, which will have only a limited effect upon spread⁵, or should they be used as catalytic and stimulus levers for new approaches to care? Projects from Thailand suggest that even if the prevention program reaches 100 percent of its targets by the year 2005, 500,000 HIV infections will have been averted, but 450,000 will still have occurred. This will increase the current number of infections by 50 percent. While few other countries have as advanced epidemics as Thailand at the moment, this issue needs to be addressed.

- To what extent should interventions be "targeted" at high risk situations, aimed at containing the epidemic rather than spread across the general population? There has often been great reluctance to target interventions too closely, because of the risks of stigmatization and marginalization of targeted population groups. Yet differentials in epidemiological risk, and cost effectiveness considerations where resources are limited, suggest that targeting is imperative.
- To what extent can interventions, and particularly targeted ones, be successfully implemented without adequate policy support? To what extent does policy support need to be built into intervention-based strategies? "The targeting of groups as described has made some contribution towards the prevention and control of HIV infection worldwide. There is, however, little room for optimism that further refinements of current interventions will make a substantive additional impact. Best estimates suggest that from one in four to one in three individuals may change their sexual or drug injecting practices in response to community participation programs. It would appear that targeted interventions derived primarily from psychological theories of behavior can be usefully supported by changes of service provision or policy."

2.8 The Nature of ANE Regional Activities

Drawing on these lessons, the Evaluation Team feels strongly that an ANE regional program can be most effective as a small, yet absolutely critical, source of catalytic money and support. There are too many borders, too many intercountry situations, too many issues of affinity, the size of the populations involved is too large, and the political, cultural, and social complexities too great for a regional program on the current scale to have a direct and immediate impact on the spread

It should be noted, for example, that in the Mwanza project, which demonstrated the effectiveness of treating STDs in preventing HIV, not ALL HIV infection was prevented; a considerable amount occurred in spite of the STD treatment.

Pamela Gillies, "The Contribution of Social and Behavioral Science to HIV/AIDS Prevention" in AIDS in the World II, Mann et al., p. 154.

of the epidemic. The program must concentrate upon contributing to the Agency's Strategic Objectives for HIV/AIDS through a series of intermediate results (IRs).

- ▶ Such efforts must concentrate on developing and demonstrating, or disseminating already developed models which can be replicated by other organizations and donors on the necessary scale.
- ► They must develop a small-scale, easily managed and replicated models, and catalytic, training, policy and research activities targeted at critical areas where maximum effect can be achieved, where need is greatest, where demand is most urgent, and where impact will be the greatest. These activities must be coordinated to fill gaps in other organizations' and donors' activities.
- ► They must be actively and widely disseminated. If a model is to be developed, how can it be replicated, and who needs to scale it up? If an innovative model activity is funded, how will it be evaluated, and how will others learn from it? What kinds of regional dissemination activities will be most effective: presentations at conferences, publications of books and "position" or "best practice" papers, workshops or study tours?
- ► They must continue to stimulate, support and unite bilateral country programs and essential minimum activities in nonpresence countries.

A regional program conceptually is not, therefore, a direct "interventionist" program with respect to the epidemic; it is a catalytic, demonstration, "teaching" program. Operationally, however, it is interventionist, in that it actively tries to identify areas in the region where it is "teaching" catalytic functions which will have most impact. It is important to constantly keep in mind a clear strategic division between the conceptual and the operational nature of a regional program. Details of the rationale for regional programming are in Annex 4.

3. THE CHANGING REALITY OF THE EPIDEMIC IN THE REGION

3.1 The HIV/AIDS Epidemic in Asia

Until a few years ago, many thought that Asia would be spared major epidemics of HIV/AIDS. Now it appears that Asia has already surpassed Africa in estimated number of new HIV infections. Yet due to generally weak surveillance, relatively few cases of AIDS have been recorded in Asia. This has meant that there has not been a great sense of urgency among policy makers to address the problem, with the notable exception of Thailand. In many countries it has been difficult to convince governments to develop proactive policies to intervene early and appropriately.

There is consequently great diversity and variability regarding the epidemic in the region, both in what is actually known about its epidemiology and extent of spread, and in what does in fact seem to be the reality. Thailand has by far the best surveillance data, followed by the Philippines. In other countries surveillance has been poor. Based on what is known or suspected, Thailand, Cambodia, Myanmar, and parts of India seem to have equally advanced epidemics. In Thailand, 2 percent of women in the general population are HIV positive, as measured in antenatal clinics; similar levels are found in parts of India. In Cambodia, some 2.5-3.5 percent of mothers seeking antenatal and family planning services were testing HIV positive in 1995, and this level appears to have been reached more quickly than in Thailand. Indonesia, Philippines, Vietnam and Laos still appear to have relatively low rates of infection. However, Vietnam and Laos share many transmission factors with mainland southeast Asian countries of relatively high HIV prevalence, and are thus likely to be vulnerable to a major expansion of the epidemic within the next few years. Vietnam is already showing rapid increases of cases among injecting drug users (IDUs) and among young men and women in the south. The lowest infection rates are currently reported in Bangladesh, North and South Korea, Mongolia, and Sri Lanka, but since there is often little surveillance data available, this may not guarantee low rates in the future.

From current data and projections, the epidemic appears to be spreading faster in Asia than in any other part of the world. It is estimated that 4.7 million new HIV infections occurred worldwide in 1995. For the first time, more infections occurred in Asia (2.5 million, or 53% of the world total) than in Africa (1.9 million, or 40%). There has been a leveling off and a decline of cases in Europe and North America, and some trends of this sort in Sub-Saharan Africa (for example in Uganda and Zambia), but only after infection rates of 20 percent or more in antenatal clinics were reached. Although prevalence rates in Asia are still well below those in Africa, the number of new cases in Asia, which contains more than 60% of the world's population, are about to exceed those in Sub-Saharan Africa, if they have not already done so. India is estimated to already have some two to five million cases of HIV infection, and the epidemic is spreading quickly. Were India to reach the same level of HIV infections as Uganda when the country's rate was 21 percent, about 190 million people in India would be infected—the size of Indonesia's

entire population, the fourth largest in the world. A strong, prompt, well-targeted response can limit the number of new cases, as demonstrated in Thailand.

3.2 HIV/AIDS as a Sexually Transmitted Infection

Factors that seem to determine HIV transmission7

An AIDSCAP/ARO Position Paper on Differential HIV rates in Asia proposes that certain factors (taken from the longer list of Piot 1994—see Annex 5) help explain much of the variation in HIV infection rates. The factors proposed include:

- levels of STIs in high-risk populations
- level of CSW customer turnover (e.g., high in Thailand cities, low in the Philippines)
- level of male circumcision
- extent of "bridging" between commercial and noncommercial sexual networks (perhaps this notion should be broadened to include links between core groups and the general population, and among different social groups within the general population).

The AIDSCAP/ARO model, based on the epidemiologic factors identified, predicts that not all Asian countries will become like Thailand, Cambodia, or Myanmar; and that in a number of countries, HIV/AIDS may spread very slowly.

HIV/AIDS in the Philippines

AIDS was first identified in the Philippines in 1984. Trained researchers are actively looking for HIV infections among groups we have every reason to believe are at highest risk, yet only 810 cases have been found as of September 1996. We must turn to factors such as those proposed by Piot or the AIDSCAP/ARO to explain this. For example, the proportion of the general male population visiting CSWs is relatively low (17-20%), the number of CSW partners per week is relatively low (c. 4-5), and levels of male circumcision are high (90% or more). Although rates of some STIs are fairly high among some very sexually active groups, there is no chancroid and relatively low levels of any ulcerative STDs. Moreover there is an apparent preference for oral sex over anal sex among men who have sex with men (MSMs). Migration to and from the Philippines tends to be to and from areas of low HIV prevalence: the Middle East, Japan, Australia, USA-not e.g., Thailand.

But attention to epidemiologic factors alone should not prompt the conclusion that interventions are not needed; we do not know if countries like Indonesia and the Philippines will eventually have significant rates of HIV infections. It certainly makes public health sense, however, to intervene in ways that minimize the chances for core groups to develop or for bridges from small proto-core groups to broader populations to develop. It is instructive to look at two countries visited

by the team, one with high HIV infection rates of 3 percent in the general population

A more detailed analysis of the ideas in this section of the Report is in Annex 5: An Epidemiological Analysis of the Spread of HIV/AIDS in Asia.

(Cambodia), and one with virtually no infection outside of a few high risk core groups. The boxes highlight these specific examples.

HIV/AIDS in Cambodia

Cambodia exhibits a quite different constellation of factors determining HIV transmission, that can explain the explosive take-off of HIV infection in this country: a thriving and widespread commercial sex worker (CSW) industry; a large proportion of men who visit CSWs (not well measured but probably comprable to Thailand, 70-80%); a double standard of sexual morality; relatively large numbers of men working away from home (soldiers, police, loggers, traders, deminers, fishermen, etc.); lack of male circumcision; 20% rates of syphilis; presence of chancroid very high; rates of reproductive tract infections; Pol Pot's destruction of the health and economic infrastructure; widespread and severe poverty; demographic imbalances from recent genocide with a high proportion of the population entering the reproductive age group; social disruption and population displacement; large numbers of widows unsupported by men; labor migration; rapid urbanization; intense cross-border population movement to and from an area of high HIV seroprevalence (Thailand); and widespread "medical" misuse of injections by untrained providers.

The team thus believes that enough is now known about HIV transmission factors to: (1) predict in a general way the nature and rate of transmission among different populations within and between countries (assuming we have surveillance and behavior data); and (2) prioritize interventions in order to ensure limited resources have maximum impact. For example, even with limited surveillance data from Indonesia, consideration of the range of epidemiologic factors suggest that HIV/AIDS will spread slowly among the majority population. Consideration of the same factors point to several subpopulations in Indonesia who are at far greater risk than the majority of the population. This is especially true for Irian Jaya, whose risk factors seem to be similar to those in Cambodia. Populations in Bali and in port cities areas such as Riau/Medan (Sumatra) and Manado (northern Sulawesi) are also at heightened risk. There are also groups at special risk such as sexually abused street children.

Nowhere is there greater need to prioritize interventions than in countries with populations the size of India, China, Indonesia, Pakistan, and Bangladesh.

3.3 The Context of Sexual Transmission of HIV: Vulnerability

The ANE Strategy identified a number of socioeconomic elements in the region (see Section 1.2, above) as contextual to developing responses to HIV. As the epidemic deepens and extends, these will become of increasing importance. The Team suggests that focusing on three additional aspects will be highly beneficial, both with regard to trying to slow the spread of HIV, and to mitigating the impact of the epidemic. These three are poverty, political realities or governance, and migration.

Poverty

Poverty is a critical factor and can be looked at in the region as being of three interelated kinds:

- Deep-rooted structural poverty, arising from gender imbalances, land ownership inequalities, ethnic and geographical isolation, and lack of access to services. Also, poverty arising from the marginalization of hill tribes and ethnic minorities, traditional rural poverty, and low status of women.
- Developmental poverty created by unregulated socioeconomic and demographic changes such as rapid population growth, environmental degradation, rural-urban migration, economic liberalization, community and political dislocation and dysfunction. The poverty of slums, marginal agriculture, and collapsing fishing or seashore communities is of this sort.
- **Poverty created by war**, civil unrest, social disruption, and refugee populations.

All three kinds have severe and deleterious effects upon individuals' and communities' vulnerability to the spread of HIV, their abilities to handle risk situations, and acceptance of and participation in prevention and care activities. The most obvious examples are the migration or "sale" of rural women and girls into urban commercial sex and their consequent exposure to very high risk situations; the migration of men and women away from stable family relationships in search of employment and their subsequent vulnerability to risk behavior; the collapse of community cohesion, norms, values, and sanctions regarding promiscuity in the face of the economic imperatives of poverty; and the high risk behavior of young people associated with inadequate education, unemployment, and urban and "modern" lifestyle exposure leading to differing personal calculations and perceptions of risks and benefits.

Political Realities

Changing political capacities and institutions in the region have an impact on the epidemic in three ways:

- Capacities in governments to identify and establish appropriate mechanisms, institutions and modalities for strategizing and planning for, coordinating, and implementing appropriately prioritized, multi-sectoral, and multi-dimensional responses to the epidemic;
- The involvement of the "private sector" in national responses: policies, plans, and mechanisms which allow the public sector, the private sector, the nongovernmental sector and communities themselves to play their full part in national responses (particularly in some of the more sensitive areas such as harm minimization or peer group approaches with particular target groups);
- The administrative, judicial, and political capacity of governments to respond to the socioeconomic challenges produced by, for example, recovery and rehabilitation after years of civil unrest, economic liberalization policies, decentralization, rapid

demographic changes, increasing participation by people in government, widespread environmental degradation, and rampant corruption.

In these different ways, the political realities strongly affect not only the kind of national response to the epidemic that may be selected, but also the capability and strength with which it is pursued.

The Social and Political Realities of HIV/AIDS in Laos

Dr. Chantone, of the National Committee for the Control of AIDS (NCCA) cites four reasons for concern about an epidemic in Laos.

- ▶ First, there is an increase in untreated STDs. There is still no national STI program. Government STI services are weak and not well attended due to the stigma associated with treatment and lack of confidentiality provided at government centers.
- ▶ Second, rural poverty is fueling migration to urban areas and across the border to Thailand. There is a lack of basic education. IEC efforts are limited by low education and restricted access to media, particularly in rural areas. The opening economy is creating opportunities for urban labor in factories, where they have few recreational alternatives.
- ▶ Third, the government cannot openly support the promotion of condoms due to cultural and political barriers. It is viewed by key party members as supporting sex rather than preventing HIV transmission. Similarly, the government will not openly address commercial sex work as a risk factor. The policy is to eradicate sex work by raiding brothels and enforcing high fines and penalties on owners and workers.
- ▶ Fourth, women and children are at a socioeconomic disadvantage with low education levels, leaving women few choices in personal prevention strategies. They are more concerned with poverty and day-to-day survival than with HIV/AIDS.

Migration

Labor migration plays a crucial role in the socioeconomic development of the region. In many areas with significant migrant populations, HIV prevention efforts have been curtailed by the illicit nature of migrants' activities (prostitution, drug use, illegal labor) and fear by migrants of deportation. While public attention has focused on the movement and trafficking of sex workers, forms of sexual exploitation and sexual networking occur in all labor groups. In addition, migrant men and women move widely across and within borders, as well as across industries. These include construction, small scale factories, gas stations, restaurants, transportation and fishing, where they have been relatively unreached by intervention messages. An understanding of immigration and labor policies and increased dialogue between grassroots migrant networks, migration researchers, and policy makers is needed to develop multisectoral strategies.

Intercountry Migration: Laos, Thailand, Vietnam Migration within Laos and across to Thailand is extensive. Sex workers are estimated to work approximately six weeks in each site, before traveling on through a network of agents and establishment owners. Seasonal migration is common in the southern provinces, while there is frequent cross-border migration to Thailand at key crossing points along the Mekong River. CARE project staff estimate at least 3000 young people migrate from Champassak to Thailand after every annual harvest. Because of the cultural and linguistic similarities of Laos to Northeast Thai and Thai, Lao migrants can live, work and travel in Thailand without easy recognition by authorities or AIDS workers.

Economic development in the region will contribute to migration and labor mobility. The Asian Development Bank is supporting the construction of an interstate highway which would link Malaysia to China (through Laos). Forty-two hydropower construction sites are planned along the Mekong River. There are numerous current and historical examples of the link between road and town construction, commercial sex and STIs/HIV. In addition, there is a Vietnamese logging presence in Khammouane, Southern Laos.

Spatial and social mobility have significant impacts on social and sexual relations. Gender and ethnic differences may exacerbate these conditions. An understanding of the social networks of labor migrants and the effect of those network structures on sexual risk, diffusion of information, and potential channels of HIV transmission would enable more efficient targeting of limited resources for direct interventions.

3.4 The Impact of the Epidemic On Mortality and Morbidity in the Region

Morbidity and mortality rates have been declining significantly in recent decades, while life expectancy has increased dramatically. Yet these gains will be threatened by the spread of the epidemic in many countries. In Thailand, over the next ten years, between 40,000 and 60,000 additional deaths will occur

annually as a result of HIV/AIDS; India may have a 20-50 percent increase in prime age (15-45) adult deaths. The African experience has shown that infant and child mortality rates will be similarly affected in the worst hit countries. While no Asian country is as badly affected as many countries in Africa currently are, pockets and particular areas within countries may well be.⁸

Responding to this situation is a major challenge for the region. Few if any countries in the region have social protection systems adequate to meet the increase in illness and death projected. Health services will be among the first to feel the crunch. A study from Sri Lanka⁹ suggests that between the years 2000 and 2005 annual average medical costs of HIV/AIDS care could amount to between seven and 22 percent of the annual increase in public sector health care expenditures; and AIDS patients for 50 percent of the increase in bed capacity during that period.

A useful study by UNDP has found that the epidemic is already affecting the Human Development Index (HDI) in a number of countries. Thailand and Myanmar are expected to take 8 and 4 years longer, respectively, to reach the point on the HDI that they would have reached without the HIV epidemic.

⁹ "The Economics of HIV and AIDS: the Case of South and South East Asia" Bloom and Godwin, eds. OUP, forthcoming.

This is a country where HIV prevalence is currently very low, with a seroprevalence rate of 60 per 100,000 as compared to Thailand at 1,875 and India at 275 per 100,000. A similar study from Indonesia estimated that the direct medical costs of an AIDS case will be more than 100 times present per capita health expenditure.

Little is currently known about the impact of the epidemic on other sectors: education, agriculture, industry, social welfare. It is clear, however, that none of these sectors is prepared for the impact of an increase in adult mortality and morbidity unseen since the great influenza epidemic of 1918.

3.5 Issues of Affinity: Regional Issues in the Coming Years

The concept of AoA, defined as concrete geographic and migratory links between countries, was central to the ANE Strategy.¹⁰ This concept has had a significant impact on how donors are looking at HIV/AIDS funding. ANE funds have been used successfully in broadening the picture of transmission within the region.

This concept can be further broadened, however, to include issues of affinity. Trafficking, migration, brothel modes of CSW organization—these are examples of concerns that are shared between one or more Asian countries, whether they happen to share borders or not. The Team feels strongly that any regional programming in the future should broaden the intercountry affinity concept to include attempts to address, as regional, subregional or intercountry issues, the wider range of HIV/AIDS-related phenomena found in the region. Working for consensus between countries, addressing issues and problems common to several countries, and helping countries learn and share from each other's experience is an important role for a regional program. Examples of issues of affinity include:

- Countries in the region undergoing rapid industrialization and its subsequent change toward consumerism, such as Thailand, Indonesia, and the Philippines will be the primary recipients of migrant labor. They will need to develop labor and immigration policies responsive to HIV transmission, develop systems of health services for migrants, create appropriate prevention strategies dealing with adolescent sexuality, and consider approaches for engaging the private sector, particularly the transport industry.
- India, Cambodia, and Thailand, where the epidemics are more mature, face serious problems of impact. These include community preparedness for care, the impact on families, including livelihood, workplace policies, and the impact of HIV/AIDS health financing issues.

See Annex 4: Regional Perspectives: a Rationale for Regional Programming, for more details of the need for inter-country, cross-border activities.

- Countries with a more active civil sector, like India, Thailand and the Philippines, are also considering the problem of NGO sustainability and cooperative arrangements between government and NGOs. Increasing private sector involvement will be critical to these countries, and models and experiences need to be shared (for example, the Thai Business Coalition on AIDS in Bangkok).
- Laos, Cambodia and Vietnam continue to face severe problems with health systems and provision of basic services. The threat of parenteral transmission in these countries is higher, and the obstacles to establishing basic STI control measures are greater.
- The degree to which health systems are integrated versus vertical also differs from country to country. In Indonesia, the Philippines, India, Nepal and potentially Cambodia, preventive strategies have attempted to integrate reproductive health services for women. In comparison, Thailand has a longer tradition of vertical health programming.

4. NEEDED RESPONSES AND INTERVENTIONS: LOOKING FORWARD

4.1 Interventions Aimed at Individual Behavior Change

The AIDS prevention strategies supported by ANE, based upon the Agency's Global strategic approach, primarily have aimed at interrupting the heterosexual transmission of HIV/AIDS by changing individual behaviors. They emphasize partner reduction, condom promotion, and STI control. Most of these behavior change strategies have targeted epidemiologically defined "high risk groups" such as commercial sex workers (CSWs) and their clients, men who have sex with men (MSM), and intravenous drug users (IDUs), or other "client" groups such as transport workers, migrants, women, or youth.

As the AIDS epidemic has matured, however, HIV/AIDS prevention approaches have evolved from an emphasis on individually focused models of behavior change to a recognition that risk reduction takes place in differing socioeconomic conditions, social structures, norms, and cultural contexts. Rather than focusing on "high risk groups" such as those stated above, or "high risk behaviors," interventionists have begun to discuss a broader range of strategies in terms of "risk situations" and "risk relationships," and to recognize the need to involve actors from all sectors in the response.

4.2 Contextualizing Behavior Change

It is now clear that programs aimed at behavior change need to be contextualized. Social and behavioral research on sexuality and sexual behavior point to structural influences on individual behavior. Levels of social structure which influence behavior include expectations of roles of gender and dominance in dyadic, sexual relationships; practices of an individual's personal network members (peers); expectations of kinship systems, family, community, and religious institutions; patterns of courtship and marriage; institutional rules governing leisure activities and gender interactions (schools, workplace, military, religious institutions); health systems promoting contraception; legal systems; economic systems emphasizing certain types of sectoral employment; political systems and ideology; and regional economic development favoring migration from poorer countries to those with more resources. As such, effective interventions must take into account these multiple levels of structure.

Systems and Processes: Mobilization and Diffusion

Successful interventions have identified and included key actors in a community or organizational system through formal and informal mechanisms of social influence. These actors range from key government policy makers, religious leaders, artists and media, medical personnel, to informal opinion leaders and other community "gate keepers." They are brought into a process comprising five key components: 1) analyzing conditions conducive to sexual risk; 2) identifying choices for change; 3) modifying institutional barriers to change; 4) seeking resources to enable change; and 5) mobilizing networks to support change. These

structural-level interventions have focused on policy, research, community mobilization, and institutional models.

Community Mobilization

Efforts to mobilize communities also show potential in developing alternative systems for HIV prevention and care. Outreach strategies concentrating on the provision of "knowledge" of HIV/AIDS transmission have evolved into more participatory approaches using techniques such as participatory rural appraisal and focus groups. These approaches focus on the local social and cultural conditions and relationships contributing to high risk in a social group or community. They often result in more innovative IEC materials which reflect the level of resources of the target group, and build on their creativity. Activating district AIDS committees using change agents from nongovernmental organizations, research institutions, or other local organizations can lead to a wider range of responses in a village, district, or urban community setting. Successful interventions indicate that the wider the choices available for change, the more likely the change will occur and be sustained.

Institutional Mobilization

AIDS prevention efforts that mobilize institutional structures also show promise for reduction of high risk sexual behaviors. These approaches examine institutional structures and relations, and find appropriate mechanisms for integrating HIV/AIDS issues into existing programs. Institutions that have been effectively mobilized to respond to HIV/AIDS include workplace settings, military structures, religious institutions, educational programs, and public health services. Institutional responses take into consideration prevention, counseling, accommodation, equity in employment, and confidentiality.

Gender Issues

HIV/AIDS interventions which address the prevention needs of women, including the underlying power differentials and meanings in heterosexual relationships, are also undergoing development. They include: analysis of gender-power relations in local settings; peer education approaches which utilize networks of influence among women, including female commercial sex workers, factory workers, and adolescents; the development of positive messages for women's bargaining and negotiation; integrating treatment and prevention of HIV/STIs into family planning and maternal child health clinics; and establishing networks of women's organizations, many built on the reproductive health and women's movement, to share strategies and influence policy and programs.

Social Marketing

Social marketing is a powerful tool in any comprehensive AIDS program. Its advantages include:

• It is highly acceptable politically, in both the domestic and international arenas. Betting programs approved and "off the ground" therefore is fairly straightforward.

- Given the relative slowness of programming for the expansion of condom distribution through the public sector, it is probably the most effective way of accomplishing the rapid expansion needed to meet the onslaught of the HIV epidemic.
- It is likely to strengthen the private sector and civil society involvement in an overall response. This is particularly useful when assembling a network of private sector players to meet service delivery and associated needs.
- Since conventional public health programs often do not manage IEC-related activities well, social marketing offers effective—and often innovative—marketing techniques for application in awareness-raising and similar efforts.
- It can target hard-to-reach groups that conventional methods have difficulty approaching (such as CSWs, IDUs, or gay groups). Social marketing with sex workers in Bombay is a clear example of this advantage.

Social marketing also features some disadvantages:

- It relies upon an individual behavior change model, carrying the expectation that individuals make individual purchases. While this assumption may adequately apply to family planning interventions, it is clear that sexual behavior (and related decisions) are contextually mediated.
- It is often seen to be only a technique for promoting condoms. In situations where condoms are not the critical issue (as in IDU transmission), the method can be overemphasized.
- Social marketing on its own is not necessarily sufficient as a response. While enormous increases in condom distribution have been credited to social marketing programs, evidence on actual condom use is actually fairly limited, and there is no evidence thus far to show that condom use has actually reduced the incidence of infections.
- There is some evidence that where public distribution systems are strong and effective, social marketing efforts are relatively less successful, since they are faced with competition from the public system.
- Many social marketing programs have had great trouble attaining financial sustainability.

In summary, while social marketing is an important part of any HIV/AIDS intervention strategy, its applicability and cost-effectiveness need to be carefully assessed *in view of the particular intervention context*. Since many ANE countries feature large populations, it becomes especially important to maximize economy and cost recovery by applying an appropriate social marketing

model. For example, in some Asian settings, local CBOs or NGOs may be as appropriate for IEC work as would mass media. Such localized efforts may be needed in certain countries where government policy restricts mass media references to contraceptives (as in Indonesia), or where certain subpopulations are at much higher risk than the general population (as with Papuans or transvestite CSWs).

In order for ANE programs to customize HIV/AIDS social marketing to local contexts, it will be necessary to support the data collection and analysis efforts we recommend elsewhere in this report. In the case of social marketing, we need to analyze exactly what role condoms, and the social marketing of them, will play in response to the epidemic's varying manifestations in the countries of the region.

4.3 Reducing Vulnerability

Responses to the issue of vulnerability are problematic: the factors raised are such broad, long-term development issues, for which non-HIV/AIDS specific programs are often already in place. What more can or should be done in the name of HIV and AIDS? Three things seem to be required: targeting activities in these areas more precisely to the changing situation created by the spread of HIV; paying particular attention to the needs of particular populations and situations; and, including HIV/AIDS specific activities within general capacity-building development.

Targeting Development Activities at Areas at Risk

Broad developmental activities can be targeted more precisely to the changing situation created by the spread of HIV and the concomitant clusters or outbreaks of adult illness and death which will follow it. Programs directed at improving women's status, alleviating poverty, increasing employment opportunities, strengthening community development, among other interventions, need to be targeted at areas where, for example, a growing number of HIV infections are known to exist, or where they are expected to exist, such as concentration and sources of migrant labor, marginalized populations living along transport corridors where highly mobile populations gather such as long-distance fishing communities. In addition, these broad development programs, once targeted, need to make provision for specific increases in adult mortality and morbidity: basic health services, social protection for dysfunctional families, orphans, and the poor. Such an approach needs to be integrated within mission and country development strategies.

Targeting Particularly Vulnerable Populations

Particular attention can be paid to the needs of particular populations and situations where infrastructural development will create very large demands for labor, trafficked women, and children.

Including HIV/AIDS-specific Interventions

It is important to include HIV/AIDS-specific activities within general capacity-building development: institutional reform programs (within the health and social welfare sectors, or in the form of decentralization and governance) can address the socioeconomic demands of responding to a mass epidemic; democratization and human rights programs can address the stigmatization and discrimination raised by the epidemic; economic liberalization and privatization programs need to address the worker welfare issues that will be raised.

4.4 Geographic and Social Mobility

Interventions aimed at curtailing HIV infection among migrants must take into account their differing situations.

At Borders

In border-crossing areas, intervention efforts have been undertaken with coordination of government and NGOs. For example, IEC materials have been created by NGOs in the languages of migrants in partnership with government health promotion offices. Translation and interpretation is also required by migrants seeking government health services. In many border areas, government employees speak several languages; however, allowances for linguistic differences should be planned in programs. Government health offices are limited in their ability to serve migrant groups. Hence, their efforts should be coordinated with local organizations to conduct direct outreach to migrant networks, particularly when their presence is illegal.

In-country

Once in-country, migrant networks become more stabilized, thereby offering better opportunities for longer-term interventions. Effective interventions will take into account the organization of migrant networks, and other issues of survival and protection, and will strengthen resources and referral systems available to assist them. Several approaches have been tried, for example, the development of audio tapes by migrant sex workers which describe processes of adaptation and explain what to do when put in certain situations. These tapes and information packets are then passed on within an informal sex workers' network. HIV/AIDS prevention and mitigation messages are incorporated into a program on health.

Worksite interventions are also possible, but require the cooperation of worksite managers. The use of community mobilization strategies and techniques such as participatory rural appraisal will help migrants to better understand how HIV/AIDS risk is situated in the context of their own lives. Worksite managers may assist in intervention efforts by allowing for special education and condom promotion activities to correspond to pay day. More organized orientation sessions should be conducted in industries with formal labor export policies. One such example is the Philippines, which integrates HIV/AIDS information into orientation programs prior to the departure of migrant laborers and again upon arrival home.

Policy

Finally, policy dialogue should occur among officials in labor, health, and immigration offices, along with academics and NGOs to better assess the impact of policies and their implementation on migrant populations. At the local and national levels, the discrepancies among labor, immigration, and health policies often curtail effective intervention efforts. Policy dialogue may also help to better coordinate efforts between government and NGOs. At the regional level, coordinated policies may help to address migrants' needs on both sides of borders.

4.5 Engaging Civil Society

Interaction between governmental, nongovernmental, academic, and private sectors is critical to a sustained response to the epidemic. Nongovernmental organizations have emerged as a key player in conducting AIDS activities while rooted in their communities, and in advocating the needs of people affected by HIV/AIDS. Academics and other researchers have often played a facilitating role between government and NGO sectors, particularly where NGOs have had little previous presence, or where long-standing tensions between government and NGOs have existed.

Organizational networks are an important component of an active private sector. By creating strategic linkages, organizations strengthen their collective bargaining power to create reasonable demands for government services, redefine cultural values and social relations, and combine resources to ensure broader coverage of services. Because of the horizontal nature of ties, organizational networks can provide an alternative structure to the traditional vertical relations of government to citizens. In the area of AIDS, organizational networks also play a crucial role in promoting ethics and human rights.

4.6 The Role of People Living With HIV/AIDS

The contributions of people living with HIV/AIDS to the response have been considerable. In countries slow to respond to the epidemic, testimony and advocacy, collectively and individually, have catalyzed a response. People with HIV/AIDS have formed a constituency to which donors, governments, pharmaceuticals and research agencies are held accountable. By organizing and gathering together, people with HIV/AIDS have redefined what it is to live with HIV/AIDS. They have defied what was initially believed to be a "death sentence" upon diagnosis, to create positive and healthy lifestyles and to expand their social networks and support through activism. They have developed creative and responsive outreach strategies and self-help programs, including the provision of home-based care. These efforts contribute not only to the direct provision of services, but also bring home the reality of the epidemic to people for whom it is otherwise a distant and abstract phenomenon. As governments and donors grapple with the enormous cost implications of "care," the development of these kinds of self-help,

community-based models of broader, less costly approaches to care are critical. Finally, they have contributed to the furthering of knowledge-behavioral, social, and biomedical by participating in research and helping to shape the research agenda for treatment and support.

4.7 New Directions for Social Research to Inform Programming

Social and Behavioral Research

Behavioral research will continue to be a key component of any strategy, by describing and analyzing high risk sexual practices. In some areas, social mapping has enabled interventionists to target specific locales where high risk behavior is present. These studies have been important for several reasons. First, the presence of researchers has brought questions about sexual behavior from the private into the public realm, generating new forms of discourse which enable people to speak more openly and legitimately about sexual risk. Second, research results have been used as policy instruments to generate government responses. Third, targeted research has exposed some cultural beliefs and practices associated with social relations not previously captured by survey research. However, research that focuses specifically on risk behaviors and preventive technologies is limited in application without a more in-depth understanding of cultural and social systems, structures, and processes in which those behaviors are embedded. Social research that examines community structures, social and sexual networks, mobilization processes, health beliefs, and institutional relations has direct application to the design of interventions that address risk contexts, identify stakeholders, target positions of influence, and tap existing communication channels and systems of meaning.

Cost-benefit and Cost-effectiveness Studies

Cost-benefit and cost-effectiveness analyses can successfully evaluate the desirability of alternative policy options.¹¹ Both methods require us to estimate the costs of implementing alternative policies. Cost-benefit analysis also estimates the expected benefits corresponding to each alternative. The superior policy is the one with the higher net benefits, that is, benefits minus costs. Cost effectiveness analysis is closely linked to cost-benefit analysis, except that it stops short of estimating the monetary benefits of particular policies.

Some of the difficulties in carrying out cost-benefit and cost-effectiveness analyses of HIV prevention programs can be addressed by more studies of the impact of HIV/AIDS at the household and the sectoral level, which will yield insights about the magnitude of benefits that will result by averting HIV infections.

Cost-benefit and cost effectiveness studies have been shown to be useful in policy making for HIV, as the UNDP/ADB work in Sri Lanka and China has shown (see Bloom and Godwin, OUP forthcoming).

Similarly, and particularly important at this stage of the epidemic in many countries where it is well established, will be cost-benefit and cost-effectiveness studies of alternative approaches to mitigation of the consequences of the increase in adult illness and death resulting from the epidemic. At the moment, many governments and donors shy away from what is perceived as the issue of "care"—medical treatment of those terminally ill with AIDS. However, many alternative approaches to "care" such as management of opportunistic infections and mitigation of impact are being developed. Effective programming in these areas is urgently needed, but should be based on careful exploration of alternative strategies.

5. PLAYERS AND PROGRAMS IN THE REGION

5.1 Government Programs

Outside of Thailand, the HIV/AIDS epidemic is still at this date fairly new; in most countries the first HIV cases were diagnosed in the late 1980's or early 1990's. National governments, therefore, have generally not had a great deal of time to address issues surrounding the presence of HIV/AIDS in their societies. This historical condition, combined with various cultural and political points of resistance to public discussion of sexual matters, results in the overall tendency in the region towards official denial of the presence or extensiveness of the epidemic, and governmental inactivity as the overriding response. While Thailand for years has allowed public efforts in promotion of condom use, for example, in other countries such as Nepal, the government is very watchful and selective of condom promotion efforts.

Similarly, while all countries in the region have National AIDS Control Plans, some are characterized by local observers as meaningful policy documents while those in other countries are seen as symbolic statements not taken seriously by local leadership. National AIDS Committees likewise display a mixed pattern of organizational capacity across countries. Some are led by dynamic, committed personalities and carry out at least a national consensus building function, while others are paper entities with uncertain prospects for developing into policy coordinating bodies.¹²

As one might expect from this range of political receptivity and organizational development, the levels of financial resources devoted to HIV/AIDS prevention and care also vary across the region. With an epidemic over ten years old, a rapidly growing population of PWAs, and a relatively high level of per capita income, Thailand is officially committed to spending the equivalent of more than \$70 million a year on HIV/AIDS. Other countries in the region, however, will not even vaguely approach this level of expenditure. Poorer countries, such as Laos, Cambodia, and Nepal, feature heavy dependence on external donors for continuance of programs. Countries with somewhat higher resource levels, such as India, may face substantial constraints regarding the effectiveness with which the public sector is capable of delivering services, thereby shifting a substantial programming burden to the private sector by default.

It is worth noting, however, that generally, if the picture of governmental investment is discouraging, attitudes of political leadership in Asian countries are often open to policy dialogue on HIV/AIDS issues. This suggests that there is substantial opportunity for enhancing enabling environments for HIV/AIDS activities in the region.

For a more complete discussion of the strengths and weaknesses of some National Programs in the region, see Annex 6: The *AIDS in the World II* Survey of National Programs.

5.2 Civil Society Responses

NGOs and community based organizations (CBOs) addressing HIV/AIDS—on the prevention or the care side or both—are active throughout the region. Again, however, the variation in pattern across countries is worth noting. HIV/AIDS-related private sector organizations in Thailand number more than 70, with the majority of these based in the north where prevalence has been most severe in recent years. Many of these, in turn, are focused on the care-related concerns of the growing number of PWAs and those who assist them.

Outside of Thailand, PWA-related organizations are distinctly less common. Instead, prevention-oriented groups are numerous wherever public awareness has begun to take hold and such groups are allowed to exist—that is, in all countries except Laos and Vietnam. Some of these groups are building their capacity and effectiveness by direct community service. This includes the NGOs and CBOs who participate in the implementation of ANE-funded activities.

If Thailand serves as a kind of "crystal ball," foretelling the epidemiological and social developments surrounding HIV/AIDS epidemics several years hence in some other countries, the Thai case suggests that NGOs and CBOs oriented to HIV/AIDS will proliferate in other countries where the epidemic comes to flourish. In addition, the issue of orientation of these organizations may be particularly different from those of the earlier, prevention-focused stage. In the care-focused stage, organizations may strive, as in Thailand, to turn public attention to the improvement of the health care system, to expansion of opportunities for community-based care, and to an emphasis on the society-wide responsibility for heightened prevention efforts,

addressing such issues as women's status, poverty, and child labor. How NGOs and CBOs define their agendas and their tactics will depend in part on their varying national and local environments, but arguably this shift in focus is one we may expect to accompany the maturation of the epidemic in Asia.

The implications of these developments for USAID are two-fold. First, there generally is no shortage of active and capable organizations in the region for support of public sector policy reform and private sector program implementation. Though

APCASO

The Asia/Pacific Council of AIDS Service Organizations (APCASO) is a network of organizations and groups working in the region; it is an affiliate of the International Council of AIDS Service Organizations (ICASO). Its functions are to network, support, and mobilize resources for community-based organizations and NGOs; its primary focus in the last couple of years has been the development of human rights monitoring concerning HIV/AIDS and strengthening the CBO sector. APCASO has played a key role in facilitating the inclusion and visibility of CBO responses in such international events as the Yokohama International Conference and the Chiang Mai Asia/Pacific Conference and addressing the "denial, dislike, and disgust" associated with HIV and AIDS in many official eyes.

organizations in some countries, such as Laos and Vietnam, may be in special need of capacity building assistance. Second, the public agendas of NGOs and CBOs in the region—or at least in some countries in the region—may undergo a transformation in the coming several years, as the epidemic progresses through various countries. This change in substantive focus may carry implications for the types of donor assistance called for in the future.

As the NGO sector expands, and increased efforts to strengthen it are made, issues of the accountability and coverage of NGO activities will become increasingly important.

5.3 Other Donors and Organizations¹³

There are a number of existing donor support programs in the region, some with regional mechanisms with potential for impact.

UNAIDS

UNAIDS' critical potential coordinating and focusing role is acknowledged. Its current emphasis is in capacity building in the public sector, a role many other donors see as being the special mandate of the UN system. Some concern was noted, in view of its recent formulation, in its current capacity to generate significant strategic and policy dialogue to feed into this capacity building, particularly when the reluctance of many pubic sector systems to face the problem frankly is seen as a major issue.

The strategy for UNAIDS in the region has yet to be worked out. The new "inter-country team," based in Bangkok, is considering possibilities for creating platforms for people at all levels, including PWAs, government officials, and local organizations, to develop creative regional responses and exchange experiences. It has yet to work out its regional structure, and to determine whether technical experts will be hired as part of a regional team or selected on a consultancy basis according to the demand of country programs.

The Japan International Cooperation Agency (JICA)

Bilateral Assistance

The Japan International Cooperation Agency (JICA) inaugurated its first project for AIDS prevention and control in the region in 1993 in Thailand. The project from July 1993 to June 1996 was for the improvement of laboratory technology and development of IEC materials. During this period, six long-term Japanese experts and 34 short-term experts were assigned to the project to strengthen HIV diagnostics at the National Institute of Health in Bangkok, as well as to develop educational materials about the epidemic. JICA supplied \$1.5 million of equipment and invited 16 Thai nationals to Japan for supplementary training during the period.

More details of UN and EC support are in Annex 10: Contact List

The Japanese Foreign Ministry and JICA are planning to dispatch a project formulation team to Thailand in late October 1996 for another possible cooperation program in the field. The team is also expected to have a dialogue with the AIDSCAP project in Bangkok to look at possible collaboration under the Common Agenda.

In the Philippines, JICA has a technical cooperation project for AIDS prevention and control for five years. The project is intended to strengthen a network of laboratory referral systems in the country, and to assist local NGOs with IEC and mass awareness. Currently, JICA is undertaking a baseline survey on STI clinics and developing IEC materials to be used by NGOs associated with the USAID-funded AIDS Surveillance Education Project (ASEP). In 1994 JICA also provided \$70,000 of HIV testing kits and other relevant equipment to the Philippine Department of Health and the Philippine National Red Cross in coordination with ASEP, to strengthen HIV sentinel surveillance activity and blood screening. JICA is expected to supply additional reagent and laboratory equipment until 1998.

In addition to this bilateral program in the Philippines, JICA is supporting the Research Institute of Tropical Medicine (RITM) of the Philippine Department of Health in Manila under its Third Country Training Program to conduct a regional training program, which includes a component of HIV laboratory diagnosis.

JICA currently (mid-September to mid-December 1996) has an expert in Bangladesh to explore a possible cooperation project in the country in the field of population and HIV/AIDS.

The Common Agenda

Collaborative activities in the HIV/AIDS field under the Japan-U.S. Common Agenda could create substantial, mutually complimentary activities which would be highly beneficial for both sides.

While USAID usually directly assists indigenous NGOs in developing their activities (e.g., in social marketing, outreach, behavior change communication, etc.), JICA's main counterpart is the public sector, with a primary focus on the improvement of laboratory technology and IEC technology.

With respect to regional programming, JICA is expected, in principle, to conduct its programs within a recipient country on a bilateral basis. The only exception is its Third Country Training Program. With regard to the AoA approach, therefore, where there are limitations on USAID presence in some countries (e.g., Malaysia and China), possibilities that JICA could program collaboratively in those countries, within the framework of the Common Agenda, are worth exploring. Similarly, with regard to training, since both USAID and JICA continue to conduct various types of training programs, greater collaboration and coordination could be mutually helpful.

Although JICA's direct activities in HIV/AIDS are still limited at present in the region, there is clearly room for enhanced collaboration and coordination in the future. To continue to build this relationship under the Common Agenda, continuous communication on a formal and informal basis, both in Washington and the field, is highly desirable.

Association of South East Asian Nations (ASEAN)

An important regional mechanism is ASEAN's regional program on HIV/AIDS prevention and control (1995-2000). Its primary goal is to supplement national and regional response capacity through cooperation among member countries (government to government). Program objectives are:

- 1) to prevent HIV transmission
- 2) to reduce morbidity and mortality associated with HIV infection and AIDS
- 3) to reduce negative social and economic impact of HIV/AIDS.

Its objectives are fourfold:

- 1) to exchange information and experiences on national campaigns against AIDS
- 2) to cooperate in research on AIDS and its social, cultural, economic and medical aspects
- 3) to develop HIV/AIDS education and awareness among the youth
- 4) to strengthen the collaboration of government organizations, NGOs, and private sectors in the national and regional HIV/AIDS programs.

Funding will go to a regional AIDS information and research reference center; intercountry seminars on HIV/AIDS prevention for nonhealth agencies; a study of patterns and effects of population movement which may contribute to the spread of HIV/AIDS; expert multidisciplinary group meetings to develop research proposals; workshops and seminars on youth, and for NGOs; strengthening NGO linkages; and commissioned research on multi-sectoral collaboration. ASEAN countries include: Brunei Darussalam, Indonesia, Malaysia, the Philippines, Singapore, Thailand and Vietnam. It is an appropriate body to address the labor and migration issues, particularly from the labor demand side.

ASEAN is regarded as an important mechanism to build political commitment to regional programming. Its structure has yet to be determined. Its technical body is comprised of country representatives from National AIDS programs of member countries. While ASEAN is headquartered in Jakarta, the AIDS Taskforce is rotating. Donors are encouraged to support these existing mechanisms by establishing relationships, facilitating intercountry dialogue, and providing technical expertise.

SAARC

SAARC is a less well developed inter-country mechanism than ASEAN. While a number of SAARC meetings have been held on HIV/AIDS (the most recent sponsored by UNDP and the World Bank in February 1996), little has come out of them.

5.4 Managing the ANE Regional Program

The core of USAID's planning infrastructure includes the strategic plans of its bilateral field missions. Providing support to these plans are the strategies of other units, including regional missions, Global Bureau, the Bureau of Humanitarian Response, and Regional Bureaus such as ANE. The strategic plans of all Agency operating units contribute to the overall Agency Strategic Framework. In the case of HIV/AIDS activities, all units with such activities contribute to accomplishment of Agency Objective 3.4, "Sustainable reduction in STI/HIV transmission among key populations."

In terms of strategic guidance, then, all Agency organizations work towards the same Agency-level objective. The various organizations and partners differ, however, in areas of focus and responsibility. Of particular relevance for HIV/AIDS activities in Asia are the differences and complementarities among the Missions, the Bureau for Asia and the Near East, and the Global Bureau.

Missions develop their own program strategies, complete Strategic Objective Agreements with host governments, and propose financial resource levels to AID/W. In the case of the Asia missions, strategies and resource levels are approved by AID/W through the auspices of ANE. As noted above, the mission by intention carries a country focus in its program; Agency and Bureau guidance call for it to concentrate its efforts on realistically expectable program accomplishments that respond to significant country development assistance needs.

The Global Bureau provides central technical assistance to missions and geographical bureaus on matters relating to the Agency's accomplishment of its own Agency objectives. In addition, through its own centrally-managed activities, the Bureau provides direct program assistance to missions through the Field Support mechanism. In the current case, Global Bureau's HIV-AIDS Division provides assistance to Asia missions through its AIDS Technical Support Project (ATSP). Contractors or cooperating agencies (CAs), in turn, serve as implementing mechanisms for the project. These include the AIDS Control and Prevention Project (AIDSCAP), the International HIV/AIDS Alliance, the National Council for International Health (NCIH) in partnership with the Asia/Pacific Council of AIDS Service Organizations (APCASO), the Center for Development and Population Activities (CEDPA), and The Asia Foundation (TAF).

The ANE Bureau is responsible for oversight of programs in the region and for developing a coordinated approach to the Agency's development assistance there. As an operating unit, it may develop programmatic interventions of its own, but these must complement those existing in mission programs and in Global. As the entity in the Agency focusing on concerns of the region, ANE is the locus for program efforts that address cross-border and multi- and inter-country issues.

ANE has had a formal Regional HIV/AIDS Strategy since 1993, and field activities in this area have evolved over several years. While the experience could be described in considerable detail, it may be summarized here by identifying four central operational lessons learned:

- Complementarity with mission strategies: As noted above, the mission programs constitute the Agency's programmatic core, as guided by the Agency Strategic Framework. An operational dynamic is present between missions' needs to focus their efforts on country-based priorities (sometimes derived from State Department or Congressional interests as well as Agency preferences) and the Regional Program's interest in meeting regional needs.
- ► Clarity of goals and oversight roles: ANE's experience has shown that with multiple Agency actors and partners involved in ANE-funded activities, it is advantageous to clarify early what the goals of an activity are, and who will be expected to do what to see that the activity is well designed and managed.
- ► Simplicity of implementation mechanisms: The regional HIV/AIDS effort features necessary collaboration, not only between ANE and its missions, but with G Bureau, contractors and cooperating agencies, and host governments as well. With this rather large group of interested players, efficiency and effectiveness can easily be bogged down by process issues and paperwork.
- ► Technical resources in the field: Highly skilled staff, associated training, and TA resources could, in theory, be located in Washington or some other location distant from the region. ANE's experience has shown, however, that having these resources based conveniently in the region makes a significant difference in the impact and efficiency of the activity.

5.5 Future Management Issues

There will be a hiatus between the end of the current ATSP (AIDSCAP) and the start-up of its successor. This will cut off all the Asia/Near East Bureau regional funding for activities, unless missions can continue funding from bilateral sources. There are no contractual mechanisms to continue funding ANE projects that have previously gone through AIDSCAP. ANE was able to accomplish what it did in Asia due, in large part, to the presence of, and good working relationship with, a regional contractor. With the ending of the ATSP, this mechanism is no longer available to ANE.

The Bureau faces two challenges: to find a "bridging mechanism" which will enable activities currently funded from regional sources to continue, and which will maintain the "presence" of the regional program, and to identify longer-term mechanisms for the effective management of regional activities.

With regard to the short term, the evaluation team strongly recommends that ANE find a way to establish a bridging mechanism urgently. Many of the promising models being developed will collapse before they have been fully developed if they are not continued now. Much of the goodwill, experience and presence associated with the ANE regional program will also dissipate.

In the longer term, ANE needs to establish some kind of unit within the region. Five issues need to be considered in this situation: the functions of such a unit for a regional program; the levels of staffing necessary for these functions; its location, lines of communication, and accountability; and coordination with bilateral programs.

The Team recommends that these be addressed through the establishment of a technical assistance unit in Bangkok, to include one ANE staff member. Staffing levels and the nature of such a unit depend very much upon the extent, scope, and scale of activities. The Evaluation Team finds, however, that a certain minimum number of staff is necessary, both to cover a minimum level of activity under the functions described above, and to produce the synergy of a work team necessary, given the limited resources and the nature and extent of the work to be done. The combination of skills and responsibilities could also vary.

The Evaluation Team recommends that the members of the unit be located together, in a single office, in Bangkok. Alternative locations might be Manila (where the Asian Development Bank and WHO/WPRO are), though there is relatively little direct experience with the epidemic there, and communications are not good; or New Delhi. As an alternative to having a unit together, in one office, as suggested above, there may be value in having one or two subregional USAID offices. These could divide the functions listed above between them, coordinating at long distance, electronically and by phone, and meeting regularly (perhaps in a series of countries by rotation).

If there were no regional unit in the field, ANE could fund programs that conform to current ANE AIDS Strategy, running some of them through international PVOs (those that implement through national NGOs and local CBOs) and some through UNAIDS (that involve implementation through or direct links with governments). ANE's Washington burden would increase substantially, however, and many of the benefits of the effectiveness of support and expertise within the region (see above) would be lost. The Evaluation Team does not consider this a cost effective or cost-beneficial alternative; indeed, it seriously calls into question the overall cost-benefit of a regional program.

The only remaining alternative would be to strengthen capacity to focus, strategically and operationally, on the region, within the HIV-AIDS Division of the G Bureau. The implications of this alternative are beyond the purview of this Evaluation.

Details are in Annex 8: A Regional Unit.

5.6 Working in Nonpresence Countries

The intercountry regional or subregional perspective taken by the ANE regional program highlights the difficult issue of the needs of nonpresence countries in which USAID has no official program. Examples are:

- The AoA border activities often involve a border with a nonpresence country (e.g., Laos and Vietnam);
- The need to meet the threat to presence countries of a large "epidemiological pool" of infection in a neighboring, nonpresence country (e.g., Myanmar, for India and Bangladesh);
- The need to involve groups of countries, both presence and nonpresence, in efforts to build subregional consensus on responses to the epidemic. Such groups include Thailand, Laos, and Vietnam—not to mention Yunnan Province, China; and India, Nepal, Bangladesh, Sri Lanka and Pakistan;
- The humanitarian need to respond to very severe epidemics in nonpresence countries such as Vietnam and Laos; and
- The need to use experience and human resources from nonpresence countries (e.g., Thailand) where these are irreplaceable, by virtue of their being the center of the epidemic.

Among the countries of the region, a number of nonpresence countries are likely to be particularly important with respect to HIV/AIDS in the immediate future.

Vietnam appears to have one of the fastest growing epidemics outside Thailand and Cambodia—a recent UN estimate was of 400,000-600,000 infections by the year 2000. And Vietnam is critically linked in the migration of labor, particularly sex workers among countries of mainland South East Asia.

Myanmar has the third largest estimated number of infections in the region (after India and Thailand), and perhaps the least capacity in the region to deal with the situation.

Pakistan has an estimated two to three million drug users, of whom ten to 20 percent are likely to be injecting. Experience from other countries (Thailand and India) has shown the frightening speed at which HIV can spread among a large injecting drug using populations, often within a year or two. It is therefore quite likely that Pakistan could soon have between a quarter and a half million infections (probably largely clustered in Karachi); this would make it the fourth or fifth largest pool of infections in the region.

Thailand is critical to the epidemic in the region. Not only has it the highest prevalence rate of infections, it has been experiencing the epidemic longer and on a larger scale that anywhere else. In addition, by virtue both of this experience and of its economic situation, it is one of the very

few countries in the region which has responded on an appropriate scale. As a pool of experience, resources, and training, it is unique in the region.

At the same time, it must be noted that gaining official clearance for utilization of the legislatively permitted waiver of the prohibition of USAID activities in nonpresence countries has to date been time-consuming and difficult. The discussion above, as well as references at other points in this report to the need for cross-border interventions, particularly in mainland South East Asia, should confirm that nonpresence waivers are essential to furthering USAID's HIV/AIDS efforts in the region.

Our epidemiological analysis (see Chapter 3 and Annex 5) suggests that some of the most difficult challenges in limiting further spread of HIV/AIDS infections will be in mainland Southeast Asia. Of the six relevant countries in this subregion (Cambodia, China, Laos, Myanmar, Thailand, and Vietnam) only Cambodia features USAID presence. To carry out effective interventions, even of the catalytic, model-development kind recommended, requires activities including, but extending beyond, Cambodia. Implementing HIV/AIDS programs in Cambodia, without supporting selected parallel actions in the other countries in the subregion, arguably would be of questionable value, given Cambodia's central geographical location and the numerous issues of affinity shared among Cambodia and its neighbors. In the case of Cambodia, at least, there is not likely to be a viable country HIV/AIDS program without regional efforts in nonpresence countries to complement it. The team therefore has identified at least one example of a country HIV/AIDS program that would depend directly upon activities in nonpresence neighboring countries for its long-term sustainability.

Obtaining nonpresence waivers, then, is not to be considered an "add-on" feature of a high-quality regional approach. Instead it is centrally important to advancing the Agency's efforts in areas where it potentially can make the most difference.

6. RECOMMENDATIONS

Strategy

- 1. The Regional programming approach adopted by ANE should be continued. The inter-country/cross-border nature of the epidemic in many parts of the region, and the need to respond flexibly and quickly to the new and rapidly developing epidemic mandate that this is an effective response to the epidemic in the region.
- 1.1 The Program should be part of a complementary framework within which the strategizing, planning and programming activities of the HIV/AIDS Division of the G Bureau, bilateral missions, and the ANE Bureau can be coordinated and synergized.
- 1.2 Operationally Regional Programming should be of a supportive, demonstration, catalytic, analytic, model-building nature, rather than being expected to have immediate impact on the spread of the epidemic in the region.

Objectives/Intermediate Results

- 2. The ANE Regional Strategy should be revised slightly, on the basis of experience, to focus more precisely on strategic functions of a regional, subregional and intercountry nature. In view of the regional, subregional, and intercountry nature of the HIV/AIDS epidemic in Asia/Near East, the tendency for regional, subregional and intercountry issues to be minimized in country responses, and the very unequal program response by countries, the strategy, and program should be specifically used to:
- 2.1 Develop models for limiting cross-border transmission of HIV within the region.
- 2.2 Facilitate intercountry (regional and subregional) consensus and capacity building with regard to the HIV/AIDS epidemic in the region.
- 2.3 Respond to the spread of the epidemic in the region by supporting (providing technical assistance/additional support to) HIV/AIDS programs in all ANE countries.
- 2.4 Support and disseminate results from innovative and replicable model projects responding to the changing nature of the epidemic throughout the region.
- 2.5 Support regional training, policy development, and research efforts.

Examples of some indicators which might be used to direct and monitor achievement of these intermediate results (IRs) are given in Annex 7: Indicators for Regional Programming.

Areas of Focus

3. ANE should carefully consider the range of epidemiologic and other factors that appear to determine HIV transmission, and the likely impact of the epidemic to prioritize specific initiatives and interventions, at the country, intercountry, and subregional levels. This is necessary both to target interventions appropriately, and to identify the most appropriate kinds of interventions for ANE's program.

Four areas deserve special attention:

- 3.1 **Policy and Issues of Affinity**: Achieve a multisectoral response by building consensus with other development mechanisms and addressing on a regional level:
 - legal and ethical issues addressing stigmatization and discrimination;
 - health sector issues such as training, access to care, integrated reproductive health services for women, and developing the care sector; and
 - labor and immigration policies relating to prevention and health service access by migrants.
- 3.2 **Nurturing the Response**: Strengthening nascent regional private sector and civil society mechanisms, and coordinating with other regional mechanisms, including UNAIDS, SAARC, ASEAN, WHO, and UNICEF

3.3 Continuing and Expanding Support for Targeted Interventions

- cross-border interventions and interventions for migrants
- choices for girls and women
- prevention approaches for adolescents

3.4 Addressing Impact

- developing and/or strengthening social protection systems for families and communities badly affected by the increases in adult mortality and morbidity
- strengthening health systems for the increase in costs and burdens
- responding to the needs of those infected

Some examples of indicators that could be used to both direct and monitor the development of policy are in Annex 7.

Data Collection and Analysis

- 4. Of paramount urgency is the collection and analysis of data in the region, to validate decisions about prioritization, and to determine the cost effectiveness and cost-benefit of initiatives and activities. ANE should collaborate very closely with other players, both inside and outside USAID to ensure that this is done. Data need to be collected specifically in these areas:
- 4.1 Social and behavioral sciences, particularly related to sexual behavior, mortality patterns, economic aspects of adult mortality, and migration;
- 4.2 Surveillance (both sentinel and point) of seroprevalence;
- 4.3 Cost-benefit and cost effectiveness of alternative approaches; and
- 4.4 Impact assessments in various sectors, particularly health, industry, insurance, and education.

Management

5. The intercountry, regional, and subregional perspective taken by the ANE regional program highlights the need to adddress the epidemic in nonpresence as well as presence countries. The Evaluation Team recommends that nonpresence waivers are obtained to ensure furtherance of USAID efforts in HIV/AIDS in the region.

Experience from the generally excellent working relationship between ANE and AIDSCAP in the region is that it is cost effective, strategically appropriate and locally acceptable to implement the kind of regional program envisaged from within the region rather than from Washington. ANE should be prepared to support the costs of maintaining a regional management unit, in the region, for coordination and implementation. In addition, there may be similar benefits to be gained from subregional implementation in certain geographic areas, or concerning certain thematic issues.

- 5.1 In the short term, ANE should find a way to establish a bridging mechanism urgently for continuing current activities in the region.
- 5.2 In the longer term, ANE needs to establish some kind of management unit within the region whose functions would be:
 - to coordinate the regional program (with missions, ANE, G/W, CAs, contractors, etc.)
 - to conduct strategic analyses of regional needs, program design, priority setting, etc.
 - to implement parts of the program (such as policy interventions, strategic analysis, monitoring and evaluation, dissemination, etc., or as default where ongoing activities need to be continued)
 - to manage procurements for the regional program (for a range of activities, including technical assistance)
 - to liaise with other donors and organizations in the region.
- 5.3 It is strongly recommended that this unit at least facilitates and participates in overall design of the regional strategy and program.
- 5.4 The unit should have a certain minimum number of staff, suggested at five (5), both to cover a minimum level of activity under the functions described above, and to produce the synergy of a work team necessary given the limited resources and the nature and extent of the work to be done. Such a minimum would probably be:
 - A **leader/coordinator** responsible for overall unit functioning, and coordination; and preferably to have primary responsibility for the policy, design, and strategic assessment functions.

- A quality control specialist such as a data specialist, epidemiologist, or econometrician: to have primary responsibility for the strategic analysis, monitoring and evaluation, research design, functions.
- Two **intervention specialists** responsible for designing, implementing, procuring and managing program activities. These people could be specialists in any of a number of areas (behavior change, public health, community development, etc.). The key skill for them would be identifying appropriate partners in the region. One of these would have responsibility for the coordination functions.
- An **administrator/accountant** responsible for financial and administration logistics, monitoring and control.
- 5.5 The staff of the management unit should be located together, in a single office, in Bangkok.
- As an alternative to having a management unit in one office, there may be value in having one or two subregional USAID offices, for example, one for the Mekong countries and in the Indian subcontinent.
- 5.7 If there were no regional management unit in the field, ANE could fund programs that conform to current ANE AIDS Strategy, running some of them through international PVOs and some through UNAIDS.
- 5.8 The only remaining alternative would be to strengthen capacity to focus on the region, strategically and operationally within the HIV/AIDS Division of the G Bureau.

Details of the functions, staffing, location, and lines of communication and accountability of such a unit, and some possible alternatives, are given in Annex 8.

Indicators

6. Countries and missions naturally prioritize national programs and issues. To help stakeholders maximize the benefits they can draw from a regional program, more explicit strategic objectives and indicators of program success, reflecting both the functional as well as the substantive nature of the program, should be developed in conjunction with missions and G. ANE should explore mechanisms for shared accountability for the strategic objectives and achievement of indicators thus developed.

Collaboration

7. In strategizing and programming for the region ANE should look to work with a variety of players: coordinate closely with other major donors, particularly UNAIDS, AusAID, JICA and the EC; use the wide range of NGOs and PVOs with experience and capability in the region; and emerging regional and subregional networks of private sector/civil society members responding to the epidemic. Specific responsibility for this should be part of regional implementation.

Annex 1

ANE Regional HIV/AIDS Activities FY 1993-1995

-49

ANE REGIONAL HIV/AIDS ACTIVITIES FY 1993-1996

TA to develop HIVIAIDS strategy Tat to develop HIVIAIDS strategy Curricula workshop for employees of NGOs Technical support - SMC/PSI condom promotion, IEC, etc To to AIDS Prevention and Control (APAC) Project Pilot interventions for risk groups Short-term TA for IEC and condom component of HAPP TA to strangthen ties and abilities of NGOs Policy tours Into planning and mass media development NGO development and capacity building		1	Deliverables	Contractor		ANE Earmark	mark	
The caeespo HIVALDS strategy		Activity Name/Description			F	FY 1994	FY 1995	FY 1996
TA to Genetic PHIVALIDS Strategy	Countries					\$50,000	\$100,000	
The General particles of MGOs	Bangladesh		And the second s	AIDSCAP	XX			
Conseignment and repeated in NGOS Not Conseignment and repeated building		TA to develop HIV/AIDS strategy	1000	DOIN ON THE	XXX	×		
NOO coresists workshop 1195 ALDSCAP SS		Curricula workshop for employees of NGOs	Workshop, 12/94	A00014	XXX	XXX		
Technical support - SMC-PS tecondom promotion, IEC, etc.		NGO consensus workshop	Workshop, 11/95	A Cocie			XX	
HIV/AIDS assessment and implementation plan Report, AIDSCAP S150,000		Technical support - SMC/PSI condom promotion, IEC, etc		AIDOCAL		O\$	\$	
HIVAIDS assessment and implementation plan Report, AIDSCAP S150,000 S150,000	Cambodia							
HIVAIDS assessment and implementation plan Report ALDSCAP S150,000					VII.	A/N	\$100 000	
HIVALIDS reseasament and implementation plan Report, AIDSCAP \$150,000 \$150,000	10000				() () () () () () () () () ()	CAL	XXX	
Table Alice Table Shevention and Control (APAC) Project AIDSCAP ST50,000 S25,000	-80 P.	HIV/AIDS assessment and implementation plan	Report;	AIDSCAP	400	*460,000	£100 000	
TA to AIDS Prevention and Control (APAC) Project AIDSCAP	-0.				200,001\$	non'noi e	200,0014	
Pild interventions of risk groups	RIDUIS	Take the Branching and Control (APAC) Project		AIDSCAP	XX	X		
Pilot Interventions for risk groups		I A 10 AIDO FIEVEINOLI BILD COMPONIO		AIDSCAP			X	
Table Short-term TA for IEC and condom component of HAPP		Pilot interventions for risk groups			\$150,000	\$35,000	Ç	
Short-term TA for IEC and condom component of IAPT	Indonesia			AIDSCAP	XX			
TA to strengthen ites and abilities of NGOs TA to strengthen item and capacity funded by ANE Bureau XXX XXX </td <td></td> <td>Short-term TA for IEC and condom component of HAPP</td> <td></td> <td>AIDSCAP</td> <td>XX</td> <td></td> <td></td> <td></td>		Short-term TA for IEC and condom component of HAPP		AIDSCAP	XX			
Policy tours Policy tours Policy tours Policy tours		TA to strengthen ties and abilities of NGOs			XXX			
Implementation planning and mass media development AIDSCAP NUA N		Policy tours		AIDSCAP	\$	***		and a second
No bilateral HIV/AIDS assessment and implementation plan AIDSCAP XXX X		Implementation planning and mass media development		AIDSCAP		***	e	
No bilateral HIVIAIDS activity funded by ANE Bureau AIDSCAP SSO;000 SSO	- [:				N/N	₹)N	3	
Victorial of STD workplan							•	
HIVIAIDS assessment and implementation plan AIIIBACAP XXX					\$50,000		3	
HIVIAIDS assessment and implementation plan	Mongolia			AIDSCAP	XX			
NGO development and capacity building Alliance \$400,000 \$100,000 \$ MGO development and capacity building AIDSCAP XXX XXX \$ Implementation of STD workplan ACAPSO/NCIH \$0 NGO development and capacity building ACAPSO/NCIH \$0 NGO development and capacity building Aliance \$50,000 NGO development and capacity building Aliance \$58,000 NGO development and capacity building Aliance \$58,000 </td <td></td> <td>HIV/AIDS assessment and implementation plan</td> <td></td> <td></td> <td>A.W</td> <td>¥.Z</td> <td>\$200,000</td> <td></td>		HIV/AIDS assessment and implementation plan			A.W	¥.Z	\$200,000	
NGO development and capacity building AIDSCAP \$400,000 \$100,000 \$ AIDSCAP XXX XXX \$ AIDSCAP XXX \$0 \$ AIDSCAP XXX \$0 \$ AIDSCAP XXX \$0 \$ AIDSCAP \$0 \$0 NGO development and capacity building AIDSCAP \$0 \$0 NGO development and capacity building AIDSCAP XXX \$0 \$0 NGO development and capacity building AIDSCAP XXX \$0 \$0 NGO development and capacity building AIDSCAP XXX \$0 \$0 NGO development and capacity building AIDSCAP XXX \$0 \$0 Further tunding to BRIA to promote HIV dipstick AIDSCAP XXX AIDSCAP XXX No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000 \$335,000	Morocco			Alliance			XX	
s AIDSCAP XXX XXX s AIDSCAP XXX XXX s Implementation of STD workplan AIDSCAP XXX \$0 NGO development and capacity building ACAPSO/NCIH ACAPSO/NCIH \$0 NGO development and capacity building AIDSCAP XXX XXX HIV/AIDS assessment and implementation plan Aliance \$35,000 \$0 NGO development and capacity building AIDSCAP XXX XXX Further funding to BRIA to promote HIV dipstick AIDSCAP XXX NIA No bilateral HIV/AIDS activity funded by ANE Bureau AIDSCAP XXX NIA No bilateral HIV/AIDS activity funded by ANE Bureau AIDSCAP XXX NIA		NGO development and capacity building		Allalice	CANDON			
HIV/AIDS implementation plan	Nenal			1	200 / A			
\$250,000 \$250,000	nda.	HIV/AIDS implementation plan		AIDSCAP		3		
Implementation of STD workplan	17 17				000'00Z\$			
NGO development and capacity building	Fullippines	Implementation of STD workplan		AIDSCAP	XX			
NGO development and capacity building ACAPSO/NCIH Alliance \$0 NGO development and capacity building Alliance \$50,000 \$0 HV/AIDS assessment and implementation plan Aliance \$38,000 \$0 NGO development and capacity building Aliance \$38,000 \$0 Further funding to BRIA to promote HIV dipstick AIDSCAP XXX AIDSCAP XXX No bilateral HIV/AIDS activity funded by ANE Bureau NIA NIA NIA					8			
NGO development and capacity building Alliance \$50,000 \$0 NGO development and capacity building Aliance XXX Aliance \$38,000 \$0 NGO development and capacity building Aliance Aliance \$38,000 \$0 Further funding to BRIA to promote HIV dipstick AIDSCAP XXX NIA NIA No bilateral HIV/AIDS activity funded by ANE Bureau S1,138,000 \$335,000	RSM/EA	The second secon	And the second s	ACAPSO/NCIH			8	
NGO development and capacity building \$1 \$20,000 \$0 HIV/AIDS assessment and implementation plan AIDSCAP XXX \$38,000 \$0 NGO development and capacity building AIDSCAP XXX AIDSCAP XXX Further funding to BRIA to promote HIV dipstick AIDSCAP XXX NIA NIA No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000		NGO development and capacity building		Alliance			8	
HIV/AIDS assessment and implementation plan AIDSCAP XXX NGO development and capacity building \$1,138,000 \$20 NGO development and capacity building \$20 \$30 \$30 Further funding to BRIA to promote HIV dipstick XXX AIDSCAP XXX NIA NIA NIA No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000 \$335,000		NGO development and capacity building			\$50,000			
HIV/AIDS assessment and implementation plan NGO development and capacity building NGO development and capacity building Further funding to BRIA to promote HIV dipstick No bilateral HIV/AIDS activity funded by ANE Bureau S1,138,000 \$335,000	Sri Lanka			AIDSCAP	XX			
NGO development and capacity building \$38,000 \$0 Further funding to BRIA to promote HIV dipstick AIDSCAP XXX No bilateral HIV/AIDS activity funded by ANE Bureau No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000				Allegoo			×	~
Further funding to BRIA to promote HIV dipstick Further funding to BRIA to promote HIV dipstick		1		Allance	Car no			
Further funding to BRIA to promote HIV dipstick NA NIA NIA NIA NIA NIA NO bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000	Theiland				22.5			
No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000	1 Janarie	Enther funding to BRIA to promote HIV dipstick		AIDSCAP	***			-
No bilateral HIV/AIDS activity funded by ANE Bureau \$1,138,000 \$335,000					4/2			
\$1,138,000	remen	No bilateral HIV/AIDS activity funded by ANE Bureau						
(NAV, CC5.4)								•
					\$1,138,00			

ANE REGIONAL HIV/AIDS ACTIVITIES FY 1993-1996

Activity Name/Description	Deliverables	Contractor	ANE Earmark			
			FY 1993	FY 1994	FY 1995	FY 1996
			\$400,000	\$136,000	\$50,000	
Conferences and other training opportunities		AIDSCAP	XXX	XXX		
Standarizing STD treatment protocol		AIDSCAP	XXX			
na di			\$100,000	\$200,000	.\$0	
HIV/STD assessment in Laos, Burma; CSW in Thailand		AIDSCAP	XXX			
Implementation of AIDSCAP program in Laos		AIDSCAP		XXX		
Increasing access to condoms, HIV education for displaced Burmese		AIDSCAP		XXX		
Inam		H. 1	\$100,000	\$0	\$628,000	
HIV/STD assessment and implementation plan for area		AIDSCAP	XXX			
Assessment and implementation plan - Cambodia	Report; 10/95	AIDSCAP				
Multi-year HIV prevention program in Vietnam		AIDSCAP			XXX	
ppinės			\$100,000	\$189,000	\$565,000	
HIV/AIDS assessmentand implementation plan for area		AIDSCAP	XXX			
Ethnographic research and interventions for street kids		AIDSCAP		XXX		
Islamic law related to STD/HIV interventions		AIDSCAP		XXX		
Journalist training		AIDSCAP		XXX		
IEC intervention - outreach to Filipino fisherman in Manado		AIDSCAP			XXX	
IEC intervention - Thai fishermen in Irian Jaya		AIDSCAP			XXX	
IEC intervention - commercial sex workers in Riau		AIDSCAP			XXX	
Behavior change Intervention in Lombok for Malaysian migrants		AIDSCAP			XXX	
Pilot IEC and STD management and treatment - Philippines ports		AIDSCAP			XXX	0.0 0.00
Bang/SL			\$100,000	\$200,000	\$120,000	X (X X X X X X X X X X X X X X X X X X
Cross-border intervention - Bangladeshi CSW (Dhaka/Calcutta)		AIDSCAP	XXX			
Cross-border intervention - Nepal/India		AIDSCAP		XXX		<u> </u>
Behavior change/STD treatment referral for Indian truckers		AIDSCAP			XXX	
			\$100,000	N/A	N/A	
HIV/STD assessment and implementation for area		AIDSCAP	XXX			_
			\$000,000	\$725,000	\$1.363,000	
HIV/STD asses	sment and implementation for area	sment and implementation for area	sment and implementation for area AIDSCAP	Smerit and implementation for area	Smerit and implementation for area	Smerit and implementation for area



ANE REGIONAL HIV/AIDS ACTIVITIES FY 1993-1996

Regional	Activity Name/Description	Deliverables	Contractor		ANE E	armark	
Activities	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			FY 1993	FY 1994	FY 1995	FY 1996
Training			AIDSCAP	\$234,000	\$200, 00 0	\$150,000	
Epid data collection			AIDSCAP	\$100,000	\$100,000	\$60,000	
Policy	The Continue of the Continue o		AIDSCAP	\$86,000	\$80,000	\$80,000	
Resource Center			AIDSCAP	\$42,000	\$60,000	\$40,000	
Other			CEODA	N/A	N/A	\$325,600	
	STD/HIV education activity (Nepal/India) Advocacy initiative (Asia/Pacific - WIP via G/DG)		TAF	N/A	N/A	\$250,400	
SUBTOTAL				\$462,000	\$440,000	\$906,000	
TOTAL				\$2,500,000	\$1,500,000	\$3,644,000	

File: U:\etran\123data\reg.1

06/14/96

Annex 2

Evaluation Scope of Work

EVALUATION OF ASIA AND NEAR EAST (ANE) REGIONAL HIV/AIDS ACTIVITIES SCOPE OF WORK

I. SUBJECT OF EVALUATION

This scope of work outlines a comprehensive evaluation of a range of HIV/AIDS activities in the Asia and Near East (ANE) region funded by the ANE Bureau of the U.S. Agency for International Development (USAID). While many activities are not yet completed and some have started only recently, the Bureau has decided that it is important to evaluate performance to date of activities on the ground to assess what impacts have been achieved and what lessons have been learned.

Furthermore, as the HIV/AIDS epidemic in the Asia region enters an explosion phase, it is important to reassess what strategic choices are needed to address future HIV/AIDS challenges regionwide. Given the Agency's plans to phase-down both activities and staff presence worldwide, this is also an appropriate time to consider and explore new and/or different mechanisms to manage the program. The comprehensive funding level from the ANE Bureau for HIV/AIDS regional activities for FY 1993-FY 1995 is approximately US\$ 7.5 million (See Annex A for breakdown of activities funded).

II. BACKGROUND

The Asia region represents the fastest growing HIV/AIDS epidemic in the world. By 1997, more individuals in Asia will be infected with HIV per year than in sub-Saharan Africa. In addition, the absolute number of infected individuals in the ANE region will far exceed Africa because of much larger populations. There is a critical need for ANE to support strong country-based prevention programs where the epidemic is growing fastest (India, Indonesia, and Cambodia), to facilitate efficient coordination and collaboration between country programs to share resources and experience, and to promote an effective regional response which includes a targeted approach to cross-border populations and cross-border transmissions.

As outlined in the Bureau's "HIV/AIDS Strategic Action Plan for Asia" (developed June 1993), the regional HIV/AIDS funds are used to support the implementation of HIV prevention activities throughout the region. The ANE Strategy is designed to expand the capacity of centrally-funded (Global/PHN) and mission bilateral HIV/AIDS programs and projects, which largely focus on preventing the spread of

the epidemic within specific countries. There are three specific components to the Strategy:

- Regional Activities: Training activities and sharing of data, expertise, materials, and resources across the region.
- Areas of Affinity (AOA): Behavior and epidemiologic research and pilot prevention intervention activities implemented within defined clusters of countries which address cross-border transmission issues.
- **Country Specific:** Behavioral and epidemiological pilot prevention interventions with potential for regional replication.

In 1994, the ANE Strategic Plan was revised to include the Near East region¹ and to broaden the use of Global (G) Bureau cooperating agency mechanism to address HIV/AIDS issues and to develop innovative responses to the epidemic. To date, these cooperating agencies include the AIDS Control and Prevention Project (AIDSCAP), the International HIV/AIDS Alliance, the National Council for International Health (NCIH) in partnership with the Asia/Pacific Council of AIDS Service Organizations (APCASO), the Center for Development and Population Activities (CEDPA), and the Asia Foundation (TAF).²

III. PURPOSE OF THE EVALUATION

The purposes of the evaluation are to:

- Assess what has been achieved based on the original and revised "HIV/AIDS Strategic Action Plan for Asia" and the annual workplans
- Evaluate the program performance to date and gauge the impacts and the results of the regional HIV/AIDS activities
- Assess whether the current Strategy includes activities and interventions that are best suited to meet the present epidemiological and behavioral pattern of the HIV/AIDS pandemic
- Determine the added value in having a regional HIV/AIDS program in addition to central and bilateral programs
- Analyze and recommend how the regional HIV/AIDS activities can be managed, given the shortage of funding and frequent changes in personnel,

¹Near East countries include Egypt, Jordan, Morocco, and West Bank & Gaza.

²All of cooperating agencies listed, with the exception of the Asia Foundation, are part of the AIDS Technical Support Project (ATSP), coordinated by the G Bureau.

strategic approaches, and Agency focus

Provide information and forward-thinking ideas that will assist the Bureau in refining its Strategic Plan and in developing a Results Framework for addressing HIV/AIDS for the near-term and long-term (next five to eight years).

IV. EVALUATION QUESTIONS

The following list of questions are meant to be a guide for the evaluation team. The team is welcome to add questions or areas for exploration as needed.

A. Achievement of Goals

- 1. What progress has been made in achieving stated goals in the Strategic Plan? For example, have Missions conducted an assessment and developed a plan to address HIV/AIDS in their respective countries?
- 2. Has there been a sharing of knowledge, resources, and expertise in the region as envisioned by the Strategic Plan?

B. Impacts and Results

- 1. What impacts, intended and unintended, have been achieved by the HIV/AIDS regional activities?
- 2. What pilot interventions or models (including those from other regions) have been successful? What has been done that is innovative and cross-cutting? What can and should be replicated in country or across countries?
- 3. What changes can be made in the design or implementation of activities to ensure better impacts and results?

C. Technical Soundness of Strategy/Approach

- 1. What are the present unmet needs of the HIV/AIDS epidemic which might be appropriately addressed through a regional program?
- 2. Given these unmet needs and current stage of the epidemic, is the strategy pursued by ANE a technically appropriate one?
- 3. What has been the added value of the regional program? Were activities undertaken could not have been carried out as well bilaterally by Missions or centrally from Washington?
- 4. Is the AOA approach useful and effective? How is it effective?
- 5. To what extent does the regional model foster sharing of data, information, and resources among the Missions and with other donors? Has this exchange been valuable?



D. Management Issues

- 1. Have regional activities to date received appropriate monitoring and technical oversight -- by G, ANE, and cooperating agencies? If not, what changes are needed to ensure effective management?
- 2. To what extent has the programming of regional HIV/AIDS money via G mechanisms been successful? Is this an appropriate mechanism for future activities, given re-engineering and restructuring changes? What other options are viable?
- 3. How do the Missions view the regional program?
- 4. How are decisions concerning which interventions to fund with regional money determined? Is this process appropriate? What other inputs should be solicited?
- 5. What is the level of donor coordination? How can other donors be leveraged?
- 6. Discuss the working relationship among G, ANE, Missions, and cooperating agencies with regard to the management of HIV/AIDS activities. Are responsibilities of each party clearly defined and appropriate? Has the collaboration been effective? What should be changed?

E. Future Directions

- 1. Are there recommended changes for the current Strategy?
- 2. What lessons can be learned from past and current activities and be applied to the revision/development of the new strategy and results framework?

 Given the shortage of funding and frequent changes in personnel, strategic approaches, and Agency focus, how should future regional HIV/AIDS activities be managed, in terms of staffing, funding mechanisms, and program priorities? What works best regionally? How can it be managed in limited presence/non-presence countries?
- How can future performance be measured? What would be appropriate indicators?

V. EVALUATION DATA AND METHODS

Most of the data for the evaluation are expected to be collected through key information interviews and from existing technical management documents. Existing data sources and suggestions for methods to be followed are listed below:

A. Data Sources

Internal Memos and Strategic Planning Documents:

- HIV/AIDS Strategic Action Plan for Asia, June 1993
- HIV/AIDS Strategic Action Plan for Asia and the Near East, September 1994
- Workplan: FY 93 ANE Regional HIV/AIDS Funds
- Workplan: FY 94 ANE Regional HIV/AIDS Funds
- Workplan: FY 95 ANE Regional HIV/AIDS Funds
- Memo from Carol Becker to Margaret Carpenter, April 25, 1996

General Background Documents regarding Organization and Re-engineering of USAID:

- USAID Strategic Framework
- Re-engineering documents/presentations
- G/PHN HIV/AIDS Framework and ATSP information
- Mission R4 documents HIV/AIDs sections

Technical Background Documents:

- Contractual Agreements
- Outcomes Document --AIDSCAP general background information on each country, assessment and implementation plans developed for each country, substantive analyses
- Evaluations of Activities
- Trip Reports
- Quarterly Reports

B. Method of Data Collection

- Desk review of existing data and documentation
- Interviews with knowledgeable staff of USAID/ANE, G, Missions, cooperating agencies, other donors, country governments, and clients/beneficiaries (list to be provided)
- A set of questions will be developed by the team to be used for interviews with cooperating agencies and Missions
- Site visits

VII. TEAM COMPOSITION AND PARTICIPATION

A. Skills Required

The skills that will be necessary for the overall team to evaluate these activities are the following:

- Strategic planning and program development skills
- Comprehensive knowledge and experience with HIV/AIDS issues, especially in the region
- Practical/field experience in assessing magnitude, trends, and direction of the HIV/AIDS epidemic
- Experience in evaluation and measurement of USAID health and/or HIV/AIDS activities
- Experience in analyzing the broad social/economic/legal implications and interplays of HIV/AIDS for the region
- Comparative understanding of USAID organizational and programmatic structure and management

It is anticipated that the above skill mix can be accommodated in a team of four to five members: one team leader, a person from the G/HIV&AIDS Division, and two to three consultants. Because of the broad geographical area covered by the evaluation, it is expected that the team will be divided into at least two groups and travel to different regions concurrently. Tentative countries of travel include: Thailand, Cambodia, Laos, Philippines, Indonesia, Bangladesh, India, Nepal, and London (home office of the HIV/AIDS Alliance).

B. Type of Contract/Level of Effort

It is expected that two team members -- the team leader and one other person -- shall provide approximately 32 days of level of effort each. The remaining team members shall provide 28 days of effort each. This breakdown in the level of efforts may be revised in accordance with the evaluation team's plan. This is a fixed cost contract.

VIII. PROCEDURES: SCHEDULE AND LOGISTICS

The evaluation is planned to start approximately August 1. The following is a tentative schedule for the 5-6 week period:

[Day 1-2]: Team planning meeting and briefings by ANE/SEA and G/HIV-

AIDS Division, and other appropriate Agency groups

[Day 3-8]: Review of documents

Interviews with relevant USAID/W staff

Set up initial meetings with Missions, cooperating agencies,

donors, governments, clients/beneficiaries, etc.

Submit draft data collection plan

[Day 9-26]: Site visits and interviews (includes all travel time)

[Day 27-28]: Drafting of report by entire evaluation team

[Day 29]: De-briefing of findings to USAID/W by entire team

[Day 29-32]:

Final writing and revisions by group leader and one team member

The evaluation team is authorized to work a six-day week while in foreign countries.

IX. REPORTING AND DISSEMINATION REQUIREMENTS

Prior to departure to the field, the evaluation team will submit a draft data collection plan, outlining data collection instruments to be used, the responsibility of each team member over the course of the evaluation period, and a tentative timeline of each team member's travel plans and scheduled meetings (if available) during the evaluation period.

Upon completion, the evaluation team shall submit to USAID a written report that summarizes the important findings, conclusions and recommendations. The team shall submit 5 copies of this report in draft, no later than September 30. USAID will provide comments within five working days of its receipt of the report. The team shall submit 5 hard copies of the report in final, as well as one copy on diskette (WP5.1), no later than October 15. Please note that the executive summary is to be no more than 10 pages in length, and the entire report no longer than 40 pages, not including Appendices. All reports are to be prepared in English only.

As noted in the above schedule, a debriefing to USAID/Washington by the entire team is required prior to the end of the evaluation period. In addition, a final oral briefing may be required after the submission of the final document. This can be done by the team leader alone.

X. BUDGET

Funding and support is expected to be provided by the ANE Bureau, including recruitment and payment of evaluation team members, support for all expenses related to the evaluation, and publication of the final report.

u:\etran\docs\hiv\regional.sow Last revised 06/27/96

Annex 3

Field Data Collection Instruments

- QUESTIONNAIRE 1 (Establishing realities of the epidemic)
- 1. What was the first dominant pattern of HIV transmission?
- 1a. Were there minor patterns at the same time? Which?
- 1b. What are the major patterns currently?
- 1c. What are the major patterns likely to be in the next 5-10 years?
- 2. What are the distribution of infection rates at present?
- 2a. How extensive, comprehensive are these data? What are major gaps in data?
- 2b. How reliable & valid are the data?
- 2c. What are the projections over the next 5-10 years? (For country and for special high risk groups?)
- 3. What data do we have on associated morbidity (STIs as well as OIs) and mortality? (by country and for special high risk groups)
- 3a. What are projections for (3)?
- 3b. How reliable are the data? Where are the gaps?
- 4. What do we know about major and minor reservoirs or core groups for (a) HIV; (b) GUD, esp. chancroid (c) non-ulcerative STIs?
- 4a. What do we know about patterns of sexual networking? (premarital, extra-marital, scope and extensiveness, etc)
- 4b. What do we know about patterns of IVDU? Male-male networking?
- 4c. What do we know about non-standard sexual practices (e.g., anal intercourse)?
- 4d. What do we know about patterns of male circumcision?
- 4e. What do we know about major social, cultural, demographic, economic etc. patterns that influence sexual behavior?

For example:

labor and other migration (internal & cross-border) autonomy and general status of women (by major occupational grouping (farming, marketing...) (rural and urban) disruption in marriage & family. adaptive responses to poverty or changes in economy influence of church, religious teachings gender ratios in rural and urban areas

Question to the Players)

1. Who are you?

-objective of the organization, e.g. AIDS-specific/more broad?

-active in HIV/AIDS since when?

-organizational structure, personnel etc.

2. What are you currently doing on HIV/AIDS ?

-kind of intervention (according to the checklist A)

-geographical priority

-target groups

2'. What is your plan for the next five-years ?

3. What is your "comparative advantage" of your organization?

4. Who do you think are the other key players in the intervention/program mentioned above?

-actual

-potential

5. Who are you working with/ would like to work with? on what interventions/programs and how?

e.g.

-collaborative project/program

-networking

-coordination

-technical support

-financial support

- 6. Any opinions/views on other organizations activities regarding HIV/AIDS?
- 29 -who is doing well/who is not.
- 7. What is the Government's attitude towards the HIV/AIDS ?
- 8. What is the Environment for the NGO activities on HIV/AIDS ?
- 9. (For Donors) Do you have any preference/priorities of organizations to cooperate/support?
- 10 conteste Commo feared from the previous HIL/AIDS

DRAFT
23 Sep

INTERVIEW QUESTIONS:

MANAGEMENT ISSUES

- 1. [Briefly summarize ANE Regional Strategy; show Results Framework] Based on your experience in this area, and your view of current and future programming needs, what changes (if any) would you recommend to the current ANE strategy in HIV/AIDS? Why?
- 2. How do you view the current regional program? Is it serving a useful purpose or achieving results that would otherwise be difficult to achieve?
- 3. How would you characterize the level and effectiveness of donor coordination? How might USAID's efforts better encourage commitments by other bilateral and multilateral donors?
- 4. In your view, what regional efforts so far have been managed particularly well? Why do you think this is so?
- 5. Have USAID regional activities to date received appropriate monitoring and technical oversight -- by G, ANE, and cooperating agencies? [IF YES:] In what ways has this been achieved? [IF NO:] What changes are needed, in your opinion, to ensure effective management?
- 6. To what extent has the programming of regional HIV/AIDS funds through G Bureau mechanisms been successful? Why? Is this an appropriate mechanism for future activities, especially given expected limitations in USAIDfunding and staff resources?
- 7. Based on your knowledge and experience, would you say that collaboration among G Bureau, ANE, Missions, and cooperating partners is as effective as it could be? What actions might improve working relationships and the overall effectiveness of the USAID effort?
- 8. Has USAID taken optimal advantage of opportunities in the region for supporting innovative local approaches for dealing with the epidemic? Why/Why not? Can you provide any examples?
- 9. Based on your experience with HIV/AIDS interventions locally, what kinds of data and other information do government and other policy decision makers need in order to respond adequately to the epidemic? To what extent do they have this information available to them now? What needs to be done to improve information for a better policy environment?

10. In your view, does a regional approach seem appropriate for future USAID involvement in HIV/AIDS? Why/Why not?

[IF YES:]

- a. What types of interventions would you suggest USAID focus on? Why? What would be the expected results of such interventions?
- b. What vehicles/project mechanisms would best fit current and future needs and opportunities? Why?
- c. Based on your knowledge and experience, would you suggest that this approach require presence of a USAID Mission in relevant countries in order to be successful? Why/Why not?
- d. Would the approach require the full-time presence in the region of one or more USAID Direct Hire staff in order to properly design and oversee the program? Why/Why not?

Annex 4

Regional Perspectives: A Rationale for Regional Programming

Regional Perspectives: A Rationale For Regional Programming

Various attempts have been made in the region to identify and categorize reasons for regional responses. One such is developed below¹.

- The need to work with (or target) populations who move across borders and between countries such as migrant labor (both legal and illegal), transportation workers (truck drivers, sailors), sex workers, trafficked persons of various kinds (women and children destined for prostitution, illegal immigrants, etc), refugees, etc. Such populations are often particularly vulnerable, both by virtue of being mobile and on account of the socio-economic conditions which lead them to mobility². Programs are needed at various points along their migration routes: preparing them when they leave, and supporting them when they arrive or if the route is interrupted, which cannot be handled by either the destination (receiving) or the origin (sending) country alone. In addition, the local legal status, or lack of it, of such migrants at various points, makes it difficult for the local country to respond fully and effectively.
- ▶ The need to work at borders and border crossing points. These are often poorly served with services and facilities addressing the epidemic, and by their nature seem to create risk situations for the populations, both mobile and static, who move through them: enforced idleness and boredom associated with the official/bureaucratic delays intrinsic to border crossing and recreational and commercial sex services responding to this; the vulnerability caused by the illegal nature of many activities associated with border crossing (smuggling, trafficking, etc). It seems likely that such border crossing points could well become epidemiological "pools" of infection, or clusters of "core transmitters"³.
- ▶ Of a slightly different nature, but equally important, is the presence at many borders in the region of significant populations living on both sides of the border. Along many of the borders these are often ethnic minorities, isolated and marginalized; or occasionally groups ethnically mixed, but equally marginalized. For all these border situations programs on either side need to be coordinated, and often supplemented: activities which are difficult for either country to promote. Where there are serious economic inequalities or political incongruities at the borders this coordination is even more difficult for the countries to handle alone.
- ► The need for regional coordination and advocacy as part of consensus and capacity building for a sustainable response in the region. Developing consensus on a number of policy issues (such as legal, ethical and human rights aspects of HIV/AIDS; multi-sectoral coordination;

This classification is based, with some expansion, upon that in the Assessment Report on Cambodia by the International HIV/AIDS Alliance.

Note that moving populations within countries are equally vulnerable; but these are more easily death within a country program.

³ It is possible that this is what is happening at the Nepal/India border, and at certain Cambodia/Thailand borders.

surveillance and epidemiological methods; testing, etc) requires inter-country exchange, discussion and action. Similarly, within the region, socio-economic inequalities and differences between countries contribute significantly to migration and cross-border exchange; in addition, much of the economic development planned for the region is based on increasing trade, flows of services, resource sharing and labor mobility. Under these circumstances, sub-regional capacity building and increased cooperation is essential to address the deeper, socio-economic vulnerabilities contributing to the spread of the epidemic.

- ▶ The practical advantages to be gained from facilitating collaboration between organizations and governments already working at national level, on cross border and inter-country issues, for example. A number of NGOs, local, regional, and international have developed programs in response to the kinds of situations described above; these need continued support and facilitation. Similarly, a number of countries, either through existing socio-political groupings (such as ASEAN, SAARC and APEC) or through more specific bilateral agreements, have started to look at inter-country issues in the health sector. Little of this, however, has been directed at HIV/AIDS yet. There is a great deal to be gained from supporting and facilitating the strengthening and extension of such activities.
- ▶ The economies of scale to be achieved by having some services available regionally and the opportunity for sharing of experience, exchange of ideas and expansion of successful programs and approaches between countries. The shortage of human resources adequately skilled in the complex issues of the epidemic, the lack of established education, research and training programs directed at the epidemic, and the general shortage of resources, make pooling of resources very cost-effective. Training programs that draw people from around the region, or that can be taken to specific countries or groups are preferable, at present, to attempting to develop a multitude of national training programs. However, this is an economy of scale that has a limited life-span; eventually all countries will need these kinds of resources.

Annex 5

An Epidemiological Analysis of the Spread of HIV/AIDS in Asia

An Epidemiological Analysis of the Spread of HIV/AIDS in Asia

What do we know about the spread of HIV/AIDS?

The UNAIDS/AIDSCAP joint Final Report on the Status and Trends of the Global HIV/AIDS Pandemic, based on the 1996 Vancouver Conference, is an example of one kind of thinking in global HIV/AIDS prevention: there is no mention or evident recognition of different patterns characteristic of regions of the world, other than heterosexual contact, MSM (men who have sex with men), and IDU (injecting drug users), each type varying somewhat in their contribution to overall HIV transmission. There seems to be an assumption that there is a single type of heterosexual transmission and that various populations are simply at different stages of development of the same epidemic. The report notes that for "reasons not yet fully understood, epidemics may suddenly explode..."

Much has been learned in recent years, however, about a range of biological, demographic, behavioral and societal factors that to varying (and still unknown) degrees determine HIV transmission. To explain the differences between HIV transmission in Africa and Europe/North America, Peter Piot has summarized a list of probable variables that influence the spread of HIV. These include a range of factors, ranging from HIV-1 sub-type variation, a newly discovered possible factor, to presence of other STIs, a well-established factor. As Piot observes, these factors are by no means limited to certain regions of the world.

Some of these factors facilitate transmission in a relatively direct way, e.g., presence of an ulcerative STI. Some STI experts believe chancroid is such an efficient facilitator of HIV that it deserves to be in risk factor class of its own. Other factors operate more indirectly, e.g., a high male-to-female ratio in the population (related to migration, presence of roads, urbanization) leads to an increase in casual and commercial sexual activity, which in turn increases rate of partner change, sexual mixing patterns, and the size of and rate of contact with core groups. Likewise, poverty and war engender commercial sex work, homeless adults and street children, poorly educated citizens, migration and separated families, and-we might add-high levels of immunodeficiency (Piot's first factor). Extent of circumcision among the male population seems to be a relevant variable in Africa, but not in Europe or Australia. Yet HIV is not a heterosexual epidemic in these industrialized countries.² It does seem to be a relevant determining factor in Asia and elsewhere where HIV is primarily a heterosexually transmitted epidemic.

Piot, P., "Differences between African and western Patterns of heterosexual Transmission" in A. Nicolai, HIV Epidemiology: Models and Methods. New York, Raven Press, 1994, pp. 77-82.

MSM accounts for the greatest number of HIV/AIDS cases in countries once characterized as Pattern I by the WHO. It may be that whatever protection circumcision provides in heterosexual intercourse, it not sufficient to protect partners in anal intercourse.

Factors Influencing the Spread of HIV (after Piot)

Virological parameters

Infectivity and virulence of HIV-1 strains Level of viremia (and immunodeficiency)

Local genital factors

Presence of other STDs Lack of male circumcision Use of certain vaginal products

Sexual behavior

Rate of partner change
Sexual mixing patterns
Type of sexual intercourse (e.g. receptive
anal intercourse, sex during menses)
Size of and rate of contact with core groups
Level of condom use

Demographic variables

Proportion of sexually active age groups to other age groups
Male-to-female ratio in the population
Proportion of urban population to rural population
Migration patterns

Economic and political factors

Poverty

War and social conflicts
Status of roads and mobility of population
Performance of the health-care system
Response to the epidemic

Is there a distinctive transmission pattern in Asia?

The general pattern of HIV transmission in Asia (developed largely from observations in Thailand and India) seems to be one of a relatively high proportion of the male population (as high as 70-80% in parts of Thailand) having sexual contact with a relatively small proportion of the female population, usually identifiable as "direct" or "indirect" CSWs. A "traditional double standard in sexual behavior" may underlie this phenomenon, although this is found in many parts of the world.

The pattern of many men with few women is reflected in male/female infection rates in Asia. In early stages, these tend to be 5:1, 4:1, and 3:1, then move toward 2:1 in later stages. Asian ratios suggest that the pool of at-risk women, at least in the earlier stages of the epidemic, is small; they also support the view that CSWs constitute the major core group, at least initially.

Heterosexual epidemics in Asia usually start when a significant proportion of CSWs (however defined) become HIV infected, so that they constitute a core group. A "bridge" to the general population then develops. Infected male clients of CSWs then infect their wives. Depending on the size of the proportion of men who have contact with the first core group, traffic on the bridge moves either quickly or slowly, so to speak. Infection rates among women in the general population begin to rise, as shown in ante-natal clinic surveillance. If infection rates decline among CSWs and their clients, as happened in Thailand, infection rates become more balanced among men and women. Finally, infected mothers in the general population pass on the infection peri-natally, and the number of pediatric cases begins to rise. Note, however, that this linear explanation does not take into consideration the extent of "bridging" within the general population (age-mixing, partnering between socioeconomic classes and ethnic groups).

Given the efficiency of HIV transmission from direct blood-to-blood contact, and from anal intercourse, there may be relatively high numbers of IDU and MSMs early in the development of a general HIV/AIDS epidemic, but these groups are usually quickly overtaken in numbers by heterosexually transmitted cases (Malaysia is a notable exception).

What are the major patterns of spread likely to be in the next 5-10 years?

If the forgoing pattern found in several Asian countries is roughly valid for the region as a whole, this means that most women are not engaged in high risk sexual behavior, at least compared to Africa, where a great many women who do not see themselves as CSWs may engage in sex for favors or cash as an economic survival strategy. In order to limit the heterosexual spread of HIV, it is relatively easy to target CSWs, especially if they are centralized in brothels, massage parlors, or other identifiable institutions. It becomes more difficult to reach CSWs if commercial sex is made illegal, or if "red light" districts are shut down. It is also difficult to reach high-risk women if they are free-lance, unregistered or simply poor women who sometimes negotiate sexual favors as an economic survival strategy, although as this report shows, ANE and other USAID-supported projects have developed strategies by which to reach free-lance CSWs with testing, STI treatment as well as HIV/AIDS and STI preventive education an condom provision. Efforts to target mobile male workers, such as soldiers, truck-drivers, sea-farers and those in the transportation industry, show promise in reducing male risk behavior³. It is also difficult to target larger groups of young women and men who experiment with several partners before marriage. ANE has supported a demonstration project in Bali to explore peer education and other interventions for such sexually active youth.

It is clear that if programs are to be prioritized and targeted to have maximum impact on rates of HIV transmission, there needs to be far better surveillance data than now exist. The new USAID ATSP project will probably allocate resources to development of better surveillance. There is also a great need for more and better research on behavior relevant to HIV/AIDS, especially sexual behavior. There has been a great deal of family planning research in Asia, including the WFS and DHS, but this has yielded very little on sexual behavior. Such data is needed to complement surveillance findings. To the extent that high-risk behavior occurs outside of a brothel-based commercial sex industry, studies of sexual behavior are needed to assess risk behaviors and develop interventions for specific sub-populations of women and men. Broad research questions include:

- ▶ Where do we find unsafe sexual practices and what are they?
- ► Among whom are there rising or still-high STI rates?
- ▶ Are there new or developing core groups? How do we reach them?
- ▶ What do they need?

We must be careful to consider that with intervention efforts focused primarily on commercial sex establishments, a shift occurs in sexual partner selection from sex workers to friends, casual partners and girlfriends, as in Thailand, thereby further expanding the potential spread to the general population. We must also be careful not to create the perception that it is the commercial, or transactional, element of sex that places people at risk, rather than the sexual interaction itself.

Ethnographic or other qualitative research is necessary to help answer these questions, in addition to surveys.

In the absence of empirical data to the contrary, it seems to make sense to initially target CSWs and their primary clients in order to prevent the development of new core groups. STI treatment should be a major part of this approach, in addition to AIDS/STD preventive education and condom provision. If IDUs or MSMs are found to be another core-or potential core-group, interventions with such groups are also needed. A matter of major strategic importance in the region is to validate this analysis, as it has critically important programming implications.

The Way Forward

The ANE HIV/AIDS Strategic Plan for Asia (June 1993, p.14-17) proposed a range of intervention choices, based on epidemiological data (however incomplete in 1993) about the apparent phases (called "situations") of HIV transmission in Asia. Each phase or stage exhibits certain characteristics and calls for certain interventions. The Strategy identified:

Situation 1: Low STD, low HIV in both high and low risk groups;

Situation 2: High STD in high risk group, low or unknown HIV;

Situation 3: High STDs, high HIV in high risk groups; low HIV in low risk groups;

Situation 4: High HIV in general population (e.g. as measured in ante-natal or FP clinics).

Each of these "situations" calls for its own, distinctive, most cost-effective intervention mix. As one moves down the list from Situation One to Four, earlier interventions are maintained; others are simply added.

What more do we know in 1996 that we can use to revisit this part of the ANE Strategy?

First, we know more about the biological, behavioral and societal factors that contribute to HIV transmission. There may be high STD rates in high risk group (Situation 2), but this may not lead quickly-or perhaps at all-to high HIV rates in high risk groups, depending on many epidemiological factors such as the type of STDs, the presence of male circumcision, and structural properties of social and sexual networks. The context of social, economic and sexual relations significantly affects both behaviors and the choices available to people in changing them.

For example, women in commercial sex establishments are perceived to engage in high risk sexual behavior. However, if their establishment provides information about HIV, STIs and other reproductive health issues, STD treatment, condoms and adequate support to negotiate with clients, they may actually be at lower risk of infection with clients than women in other situations are with their partners, or than they are with their boyfriends or regular customers.

From what we have seen in Thailand's mature epidemic, we can perhaps add new approaches to these situations or stages of the epidemic. For example, declining STIs and declining HIV

among primary high risk groups (the first to become infected), yet relatively high and increasing HIV infection rates among secondary risk groups (e.g., wives of CSW clients as well as socially and economically mobile single young women). Thailand seems to be in this stage. This situation highlights the need for broadening responses to address developmental, vulnerability issues in communities and societies, and strengthening integrated, community-based approaches. Strategies focused on primary risk groups or situations may need to be reassessed. Note that condom promotion and other elements of interventions appropriate for CSWs and their clients may not be appropriate for married couples, or other women who tend to associate condoms with commercial sex. New strategies for intervention will have to be developed.

)

Particularly important as the epidemic expands through these stages is the need to address the implications and impact of the spread of HIV infections. It is now clear that there is urgent need to develop cost-effective approaches to care of those infected, mitigation of deleterious community and societal responses to them, and addressing the impact of their illness and premature death on their families, households and communities. Yet a major problem in the region at present is the lack of data about the epidemic, its determinants and consequences, to guide such programming.

Focused, small-scale (rather than long-term, elaborate panel study) data collection, analysis and operational research should be a priority for the regional program; both in support of bilateral programs, and for regional issues. The region contains tremendous capacities in these kinds of areas: the need is to focus these capabilities on the HIV/AIDS epidemic.

Annex 6

The AIDS in the World II Survey of National AIDS Programs

25

The AIDS in the World II survey of Government National AIDS Programs (GNAPs)

WHO, acting through the now defunct GPA (Global Program on AIDS), between 1986 and 1994 supported the establishment of National AIDS Programs in virtually every country in the region. These were to be instrumental in laying in place many of the fundamental mechanisms for responding to the epidemic. The AIDS in the World II survey of Government National AIDS Programs (GNAPs) found, for example, that of 22 countries in the SEE Mediterranean, Northeast Asia and Southeast Asia¹, by 1994 18 (82%) had published national AIDS policy and programs documents, 12 (55%) had conducted needs assessments of the HIV/AIDS situation within their country, 12 had developed multisectoral strategic plans, and 14 (64%) had made budget allocations. They have served as important focal points for stimulating and coordinating a variety of activities from a number of players. In addition, a variety of other, civil society/private sector players established similar mechanisms. The AIDS in the World II survey also found that in 7 (32%) of the countries there was at least one group or organization outside the government which monitors and reports on human rights violations with respect to HIV/AIDS; in addition, in 8 of the 22 countries (36%) between 1 and 15% of total funds spent on HIV/AIDS related activities went through CBO, ASOs or NGOs.

It is important to review the establishment of these mechanisms since they indicate both a source of strength in the region, and of weakness. As strength, they represent established, national points of focus and action; yet in a number of countries they are still not established, or established so weakly as to be essentially non-functional (e.g. Bangladesh, Nepal). As weakness, by virtue of being largely established within Ministries of Health, and usually as vertical, isolated programs, they tend to confine and constrain the scope of response possible². The following tables, using a selection of countries from the *AIDS in the World II* survey, illustrate these constraints.

Table 1. Changes in the number of places (e.g., clinics, schools, brothels, bus stations, etc.) in which distribution of condoms is allowed between 1990/92

Country	'90	'92	% change	
Thailand	8	8	-	
Sri Lanka	3	4	30	
Nepal	5	4	-20	
India	0	0	-	
Vietnam	4	4	-	10
Могоссо	2	2	-	
Jordan	3	3	-	

Algeria, Israel, Jordan, Kuwait, Lebanon, Morocco, Oman, Syria, Tunisia, Bhutan, China, Hong Kong, Japan, Taiwan, Vietnam, Brunei, India, Malaysia, Nepal, Singapore, Sri Lanka, Thailand

The location and status of National AIDS Programs is a vexed issue: the example of the Thai Program, acknowledged to be one of the strongest in the world, but which has vacillated back and forth between the Ministry of Public Health, the Prime Minister's Office, and the National Economic and Social development Board, is apposite.

This table shows how slowly changes in policy have happened.

Table 2. Potential Indicators of Policy Depth

Country	Mobilization of MCH/FP programs for HIV	Legal restrictions based on HIV status	% program funds spent on NGOs	% program funds spent on prevention
Thailand	No	No	4	15
Sri Lanka	No	No	15	30
Nepal	Yes	No	15	40
India	No	No	0	46
Vietnam	Yes	No	0	n/a
Morocco	Yes	Yes	n/a	32
Jordan	No	Yes	15	47

Table 2 suggests some of the variability in important policy areas: the need to broaden the response beyond vertical HIV/AIDS programs; the need to address legal/ethical/human rights issues; and the involvement of the private sector/civil society. Tables 3 and 4 extend this, identifying some specific issues relating to the narrowness or breadth of GNAPs, and the strength of the support and coverage in the country.

Table 3. Potential Indicators of Program Capability

Country	No behavioral studies conducted 90-92	Training of Managers for HIV in other Ministries (% achieved)	Training of decentralized (e.g. local the Government) managers (%)	Training of NGO managers (%)
Thailand	4	n/a	n/a	n/a
Sri Lanka	2	0	70	0
Nepal	0	5	10	10
India	3	50	50	20
Vietnam	2	100	100	100
Morocco	2	n/a	n/a	n/a
Jordan	1	n/a	n/a	n/a

Table 4. Potential Indicators of Program Strength

Country	NAP Managing all HIV activities	NAP Implementing all HIV activities	Problems of political support	Problems of Public Support
Thailand	No: shared with other agencies	No: shared with other agencies	Low	Low
Sri Lanka	No: shared with other agencies	Yes	Low	Medium
Nepal	n/a	n/a	Low	Medium
India	Yes	Yes	n/a	Medium
Vietnam	Yes	No: shared with other agencies	n/a	n/a
Morocco	Yes	Yes	Low	n/a
Jordan	Yes	No: shared with other agencies	Low	Low

But perhaps more important is the question of time-scale that is raised by the GNAPs. Putting in place the public and private sector mechanisms and programs to handle/generate these responses takes time, as few countries have them ready made. Few, if any programs are designed to deal with the nature of the spread of HIV (largely through intimate, personal, sexual behavior), the kinds of behaviors and situations associated with this spread (concerning particular kinds of sexual interactions, and their frequency), and the scale on which it takes place (particularly in the very large societies of Asia). As the experiences of Australia and America show, even in wealthy societies, with well-established social institutions, it can take several years to put in place the full range of policy, legal, service provision and social acceptance-generating mechanisms to deal effectively with even relatively small numbers of infections, in relatively well-defined situations. In societies which find it particularly difficult to deal with the nature of the spread of HIV (because of cultural or social disinclination to have sexual behaviors and relationships a part of public discourse), where widespread poverty reduces access to health and social welfare services for large numbers of citizens, or where socio-economic change is challenging social and political institutions, a much longer time, possibly decades, is necessary to put in place adequate mechanisms to respond to the presence in the country of HIV infections (regardless of their number). As Table 5 shows (using a few indicators of the mechanisms necessary for an adequate response, and for a few countries in the region), even several years after the recognizable presence of HIV infections in the country, many of the basic mechanisms are not adequately in place.



Table 5. Some Necessary Mechanisms for Responses to the Epidemic

Country	No of years since at least 10 AIDS cases reported	Voluntary HIV testing	Free condom distribution	Support for CBO/ASO/NGOs	Blood screening
Jordan	7	NE	NE	NE	SA
Morocco	9	NE	SA	NE	SA
China	4	NE	NE	NE	NE
Vietnam	3	SA	NE	NE	NE
India	9	SA	NE	SA	NE
Nepal	4	NR	NE	NE	SA
Sri Lanka	5	SA	NE	SA	SA
Thailand	9	NE	SA	NE	SA

Note: NE = needs expansion, NR = not required, SA = sufficiently available; source: AIDS in the World II, Mann et al., 1996

For USAID, GNAPs remain a critical contact point: for mission-based, bilateral programming, GNAPs must be the primary channel; for regional, or subregional programming, GNAPs are one of the important vehicles for programming. And where intercountry efforts are to be made, GNAPs are critical. Taking into account the implications of the strengths and constraints presented by GNAPs is therefore essential.

Annex 7

Indicators for Regional Programming

Indicators for Regional Programming

This Annex presents examples of some indicators which might be used to direct and monitor achievement of the revised Objectives/IRs for the ANE Regional Program. The indicators suggest some of the substantive areas through which the objectives can be achieved; essentially these represent a broadening of the original six priority interventions of the strategy to include longer-term responses to the impact of the epidemic. In the following sections, details of some of the specific activities envisaged under these areas are provided, along with possible indicators monitoring them.

Indicators

- 1. Development of models for limiting cross-border transmission:
 - 1.1 Models developed
 - 1.1.1 models implemented and evaluated
 - 1.1.1.1 sites and social/behavior change strategies selected
 - 1.1.1.2 tools developed for implementation and monitoring/evaluation
 - 1.1.2 situations identified where models are needed (e.g., border situation, target populations, social organization of migrants, geographic areas)
 - 1.1.2.1 epidemiologic, socioeconomic, cultural and migratory differentials examined
 - 1.1.2.1.1 data collected
 - 1.1.2.1.1.1 analytic tools developed
 - 1.2 Known models disseminated
 - 1.2.1 model tested in new setting
 - 1.2.1.1 situations identified where models are needed which are similar to areas where other models were tested
 - 1.2.1.2 model for dissemination or replication identified 1.2.1.2.1 existing model validated or refined
- 2. Facilitation of intercountry consensus and capacity building
 - 2.1 Countries accepting consensus (on, e.g., legal issues, STD issues, status of PWAs, private sector policy, etc)
 - 2.1.1 Intercountry policy/consensus meetings held
 - 2.1.1.1 Intercountry for aidentified
 - 2.1.1.2 Advocacy tools for intercountry issues developed
 - 2.1.1.2.1 Intercountry issues identified
 - 2.1.2 Countries supporting cross-border or intercountry programs
 - 2.1.2.1 Cross-border models adopted
 - 2.1.2.2 Policy-makers exposed to intercountry experiences, study tours, model demonstration, etc
 - 2.1.2.2.1 Concerned policy-makers, local actors, etc identified
 - 2.1.2.2.2 Cross-border issue identified

- 3. ANE Mission programs in HIV/AIDS strengthened
 - 3.1 Number of Mission strategies revised to further complement the ANE regional strategy
 - 3.2 Number of Mission performance monitoring plans with indicators or targets refined based on added value of the regional program
- 3.3 Number of Missions with "satisfactory" or higher overall levels of customer—satisfaction with the regional program
- 4. Pilot projects responding to the changing nature of the epidemic
 - ▶ Number of pilot projects supported
 - Number of pilot projects disseminated
 - ▶ Number of innovative areas in which pilot projects supported
- 5. Regional training, policy development and research efforts
 - Areas in which training supported
 - ▶ Number of people trained/supported
 - ► Areas in which research supported
 - ▶ Number of research studies supported

An Emphasis on Policy

The extent to which bilateral USAID Missions feel it appropriate to include HIV in their policy dialogue with countries depends on local circumstances. The need to contextualize responses to the HIV epidemic, however, and the urgency of mobilizing expanded responses to it, suggest that this is vitally important, and should be very specifically supported by the ANE Regional Program. Using the data and analyses referred to in the previous section, advocacy tools and policy levers can be developed for this purpose. This can be synergized by participating in, and if necessary initiating, regional or sub-regional policy dialogue, whether in inter-country fora, such as ASEAN or SAARC, or in donor fora, such as UNAIDS, or in specifically designed activities, such a workshops, Conferences and meetings.

Areas for Policy Dialogue

The most important areas for policy dialogue are:

- Mobilizing resources, involving stakeholders and establishing mechanisms for effective responses
 to the epidemic: such as getting adequate budget allocations made to HIV programs, supporting
 National AIDS Program structures within Government, involving other public and private sectors,
 and creating general awareness and support for the national response.
- Addressing the impact of increased morbidity and mortality on sectoral and social welfare systems: such as the impact on the health system, the health, social and psychological needs of those infected and their families, the likelihood of increases in poverty as a result of AIDS deaths, and putting in place "survivor assistance" programs for widows, orphans, the elderly, etc

Indicators for Policy

While monitoring of conventional indicators, such as condom sales or distribution, reduction in number of partners or the incidence of STDs remains critical, we need to expand the range of indirect indicators being used to measure country and community level responses to the epidemic. These, though gross, are relatively easy to monitor and measure, and indicate the emergence of some of the environmental changes necessary for effective prevention and care programs to take place. Some examples of sets of hierarchies of such indicators that could be used might be:

- 1. HIV/AIDS specific official policy and strategy developed (and published)
 - 1.1 Relevant areas addressed within the policy (e. g. legal issues, hospital care, doctors' responsibility, employment, involvement of various Government departments, survivor assistance, etc.)
 - 1.1.1 Anti-discrimination legislation in place (passed by Parliament, etc)
 - 1.1.1 Anti-discrimination drafted
 - 1.1.1.2 Judges/Magistrates trained/oriented
 - 1.1.2 Hospital HIV policy promulgated
 - 1.1.1.1 Doctors oriented
 - 1.1.1.2 Nurses oriented
 - 1.1.3 Labor/ Social Welfare Ministries/Departments with HIV policies
- 2. Involvement of communities and NGOs
 - 2.1 HIV responses in communities being mediated by NGOs
 - 2.1.1 NGOs working on HIV
 - 2.1.1.1 NGOs getting funding under NAP
 - 2.1.1.1 Legal funding mechanisms for NGOs simplified
 - 2.1.1.2 Donor/Government resources allocated to NGOs
 - 2.1.1.3 NGOs preparing Program/Proposals
 - 2.1.1.3.1 NGOs identifying needs
- 3. Raising awareness and ensuring societal support
 - 3.1 HIV/AIDS issues recognized/supported in mass media, parliament, local government, etc
 - 3.1.1 Appropriate issues mentioned: infection, control, care, community responses, etc
 - 3.1.1.1 Social and media "gate-keepers" oriented
 - 3.1.1.2 Advocacy tools/materials developed
 - 3.1.1.2.1 Knowledge & attitudes studied
 - 3.2 HIV/AIDS issues part of educational system
 - 3.2.1 HIV/AIDS included in school curriculum
 - 3.2.2 Teachers oriented
 - 3.2.3 School policy regarding HIV+ children and staff promulgated

- 4. Addressing impact
 - 4.1 Public and Private sector social protection programs running
 - 4.1.1 Impact policies developed and in place
 - 4.1.1.1 Impact assessments conducted (e.g. economic impact, impact on health sector, increase in orphaning, insurance industry, impact on railways, employment etc)
 - 4.1.1.1.1 Projections made of numbers and locations of orphans, widows, etc
 - 4.1.1.1.2 Cost-benefit studies developed for specific issues/situations
 - 4.1.2 Programs designed for high vulnerability areas (e.g. sources of labor migration, transportation corridors, low female status, etc.)
 - 4.1,2.1 High vulnerability areas identified
 - 4.1.2.1.1 Labor migration patterns studied
 - 4.1.2.1.2 Vulnerability factors identified in specific situations
 - 4.2 Health sector impact absorbed
 - 4.2.1 Changes in health delivery and health seeking patterns identified
 - 4.2.1.1 Projections of morbidity and mortality changes identified
 - 4.2.1.2 Identification of costs of introduction of universal precautions, disposable needles/syringes, blood screening, etc
- 5. Responding to the needs of those infected
 - 5.1 Health, economic and social support programs developed and running
 - 5.1.1 Referral and medical care systems in place for people with HIV/AIDS
 - 5.1.1.1 Health staff trained
 - 5.1.1.2 Health care system in place (drugs, etc)
 - 5.1.1.2 Health care needs (testing, medication, home/ community based care, alternative treatments) assessed
 - 5.1.1.2.1 Biomedical needs assessed by researchers
 - 5.1.1.2.2 Needs as assessed by PWAs
 - 5.1.1.2.3 Health systems needs as assessed by health care providers
 - 5.1.1.3 Community support systems organized
 - 5.1.1.3.1 Self-help groups formed
 - 5.1.2 Social support systems in place
 - 5.1.2.1 Needs of PWAs integrated into social welfare system
 - 5.1.2.2 Community-based responses supported
 - 5.1.2.1 Assessments conducted addressing economic and social needs (supplemental income, income-generating activities, family and community support mechanisms)
 - 5.1.3 Legal systems in place
 - 5.1.3.1 Needs of PWAs integrated into legal and employment systems
 - 5.1.3.2 Referral, advocacy and information mechanisms in place
 - 5.1.1.2.1 Assessments conducted addressing social needs (legal protection, workplace issues, etc.)
 - 5.1.4 Psychosocial systems in place
 - 5.1.4.1 Needs of PWAs and their families integrated into support systems (e.g., family, religious groups, PWA support and self-care groups)
 - 5.1.4.1.1 Assessments conducted addressing psychosocial needs (counseling, emotional support, self-esteem, self-care)
 - 5.1.4.1.1.1 Psychosocial needs as assessed by PWAs
 - 5.1.4.1.1.2 Psychosocial needs as assessed by families
 - 5.1.4.1.1.3 Psychosocial support assessed by institutions

These indicators could be used both to direct and monitor the development of policy.

Annex 8

A Regional Unit



A Regional Unit

There will be a hiatus between the end of the current ATSP (AIDSCAP) and the start-up of its successor. This will cut off all the Asia/Near East Bureau regional funding for activities, unless, (as is the case in Indonesia where the HAPP Project will pick up the activity) missions can continue them from bilateral sources. There are no contractual mechanisms to continue funding ANE projects that have previously gone through AIDSCAP. ANE could contract PACT or PATH, for example, directly; but then a greater managerial burden would fall on ANE. ANE was able to accomplish what it did in Asia due, in large part, to the presence of, and good working relationship with, a regional contractor. With the ending of the ATSP, this mechanism is no longer available to ANE.

The Bureau faces two challenges: to find a "bridging mechanism" which will enable activities currently funded from regional sources to continue, and which will maintain the "presence" of the regional program, and to identify longer-term mechanisms for the effective management of regional activities.

With regard to the short term, the Evaluation Team strongly recommend that ANE find a way to establish a bridging mechanism urgently; many of the promising models being developed will collapse before they have been fully developed if they are not continued now; much of the goodwill, experience and presence associated with the ANE regional program will also dissipate.

In the longer term, ANE needs to establish some kind of unit within the region. Five management, or operational, issues need to be considered in this situation: the functions of such a unit for a regional program, the levels of staffing necessary for these functions, its location, lines of communication and accountability, and coordination with bilateral programs. The Team recommends that these be addressed through the establishment of a unit in Bangkok, to include one ANE staff member.

Functions of a unit¹ for a regional program The unit would have a number of basic functions: administration, logistics, accounting, etc, and five primary program functions:

- to coordinate the regional program (with missions, ANE, G/W, CAs, contractors, etc.);
- to conduct strategic analyses of regional needs, program design, priority setting, etc.;
- to implement parts of the program (such as policy interventions, strategic analysis, monitoring and evaluation, dissemination, etc, or as default where on-going activities need to be continued);
- to manage procurements for the regional program (for a range of activities, including technical assistance); and
- to liaise with other donors and organizations in the region.

For simplicity the term "unit" is used, rather than "regional office", to avoid confusion with the present AIDSCAP Regional Office in Bangkok, and the Bureau's office in Washington; though this analysis is based upon assessment of the kinds of functions that both have had in implementing the ANE regional program.

It is strongly recommended that this unit, in collaboration with ANE, G, and missions facilitates and participates in overall design of the regional strategy and program.

A matter of some discussion in the region concerns the "value added" of such a unit; why it is necessary at all. It was suggested to the Evaluation Team in one case that these functions could be quite well managed from Washington, either through the ANE Bureau itself, or through the HIV/AIDS Division of the G Bureau itself. The Evaluation Team feels strongly, however, that this is not the case. Three reasons for this are:

- ▶ There was a unanimous response from everyone the Team met that the timeliness, familiarity, consistency and local expertise of the support and technical assistance provided under the ANE regional program was a major benefit, and often critical to success. This was made possible by having this available in the AIDSCAP Regional Office in Bangkok. It was equally strongly felt that this level of availability, timeliness, familiarity, consistency and local expertise would be difficult to achieve if the TA and support were only available from or through Washington.
- ▶ There is clear evidence of the cost-effectiveness of having such implementation support and TA locally available within the region. Compared to travel outside, or to and from the region, airfares within the region are relatively low; connections between countries are by and large excellent; travel time within the region is relatively short; other communications are good (telephone/fax), or rapidly improving (e-mail, Internet, etc). A number of country staff were candid that it was worth their while to spend their scant budgets on TA from Bangkok; but they would not have considered it cost-effective to have to pay for TA from America. Similarly, management "turn around" time (the processing of management issues) was much quicker between countries and the Bangkok office than between countries and Washington (AIDSCAP HQ).
- ▶ While there is much to be gained from the global perspective and access to the latest practice that comes from managing centrally, the extent and nature of the epidemic in the region (see Chapter 1), the diversity of resources and responses, the dynamic nature of the region's socio-economic situation and the sheer size and number of countries in the region means that managing within the region has its own imperative. It is difficult for people not based in the region to keep up with what is happening; there are developments in the region that in many cases may be ahead of the rest of the world; and there are socio-cultural and political sensitivities and realities that visitors to the region often find difficult to recognize and adjust to.

These considerations become particularly important in view of the increasing pressure on human resources within USAID. As missions struggle to do more with less, the timeliness, cost-effectiveness and appropriateness of regional support for HIV/AIDS will be at a premium.

Staffing a Unit for a Regional Program

Staffing levels and nature of such a unit depend very much upon the extent, scope and scale of activities. The Evaluation Team finds, however, that a certain minimum number of staff is necessary, both to cover a minimum level of activity under the functions described above, and to produce the synergy of a work team necessary, given the limited resources and the nature and extent of the work to be done. The combination of skills and responsibilities could also vary. The assessment of the evaluation team after its visits to the field, however, is that such a minimum would probably be:

- Leader/coordinator: responsible for overall unit functioning, coordination; and preferably to have primary responsibility for the policy, design and strategic assessment functions.
- Quality control specialist: a data specialist, epidemiologist, or econometrician: to have primary responsibility for the strategic analysis, monitoring and evaluation, research design, functions.
- Intervention specialists (2): responsible for designing, implementing, procuring and managing program activities. These people could be specialists in any of a number of areas (behavior change, public health, community development, etc); the key skill for them would be identifying appropriate partners in the region. One of these would have responsibility for the coordination functions.
- Administrator/accountant: responsible for financial and administration logistics, monitoring and control.
- Support staff: secretaries and drivers.

Of primary concern is the differentiation between implementation functions and technical assistance functions of this unit. This is a major operational constraint. The recommendation above combines both but attempts to concentrate technical assistance in areas where this is less likely to be available (with respect to the HIV/AIDS epidemic) in the region. Much of the more conventional skill and experience (e.g. with respect to STD management, social marketing, etc) is largely available for procurement, either in countries, or in international PVOs operating in the region (see table 4.1, above).

It is also recommended that ANE decentralize as much oversight as possible for the regional program, by posting a member of ANE to be in this unit. Ideally, such a person would be the unit Leader. Should this not be possible, financially, procedurally or politically, it is recommended that this person should function within the unit as a member of the team, but possibly with specific responsibilities (such as for policy dialogue and liaison with other donors, missions, etc); a draft job description for such a person is at the end of this annex. It is important that there is no duplication of managerial or technical authority under these circumstances.²

Location of a unit for a regional program The Evaluation Team recommends that the members of the unit be located together, in a single office, in Bangkok; for the following reasons:

- Most regional coordination (e.g. UNAIDS, AusAID, ESCAP, UNICEF, Save the Children, FHI, etc) takes place there and there is a need to coordinate with other regional efforts;
- It is a non-presence country: if there was a strong and growing bilateral program in the host country for the unit, it could be overly pulled into local issues and this would detract from regional attention and concerns;
- The epidemic is the most advanced in Thailand and the country response can serve-and has served-as a model and "laboratory" for elsewhere in Asia. There is much to see and learn from in Thailand; lessons both good and bad. Most future conceptual and operational advances will be piloted in Thailand (either indigenously or externally supported)
- Much of the regional expertise and experience in the epidemic is based in Thailand: the leading NGOs models, both international and national; the surveillance models and experience; the care and mitigation models and experience.

Note the delay in the Laos program created to some extent by lack of clarity in line of authority and technical assistance between the RSM, and the HPN officer and the AIDSCAP ARO.

- Thailand is a communication and transportation hub for much of the region; the alternatives are Singapore and Hong Kong.
- Many of the countries most seriously affected by the epidemic are close to (and often share borders with) Thailand: Cambodia, Myanmar, Laos, Vietnam, China and (directly across the Bay of Bengal) India and Bangladesh.

Alternative locations might be Manila (where the Asian Development Bank and WHO/WPRO are), though there is relatively little direct experience with the epidemic there, and communications are not good; or New Delhi, where many of the same conditions as in Thailand apply, with the exception of good communications.

Locating the unit in a presence country might be difficult. Very restrictive ceilings have been imposed on how many total personnel a mission can have; direct hire, PSCs and PASAs are all counted the same-the total number is what counts. Adding an ANE officer (as envisaged above) would bump out an existing officer.

Sub-Regional Offices

As an alternative to having a management unit together, in one office, as suggested above, there may be value in having one or two sub-regional USAID offices. These could divide the functions listed above between them, coordinating at long-distance, electronically and by phone, and meeting regularly (perhaps in a series of countries by rotation). Such a mechanism would probably not, in reality, be as cost-effective as a single office, but is worth considering. Probably two sub-regional offices could be suggested: one for the Mekong countries of South East Asia, and one for the sub-continental countries of South Asia. The other, island countries would need to be covered by one of these offices.

It appears that the Mekong countries of mainland SEE Asia form a rather distinctive HIV transmission pattern-or cluster of patterns due to a common constellation of socioeconomic and epidemiologic risk factors. Moreover, most non-presence countries are found in the Mekong region. Because of these factors and because of significant movement of populations between the borders of these mainland countries, there is reason to expect the epidemic(s) in Laos and Vietnam to develop along the lines of those of Thailand, Cambodia and Myanmar. There is less reason to expect that the epidemics in Indonesia and the Philippines will develop this way. Arguably, current responses in these latter countries are appropriate to the current threat of HIV/AIDS in these countries, even if more and better prioritizing and targeting is needed. The same cannot be said for the Mekong countries with the exception of Thailand. A sub-regional office could be placed in Cambodia; in fact Cambodia is the one mission in the region without highly restrictive personnel ceilings, meaning that an ANE sub-regional coordinator would be accepted, in fact welcomed in the mission.

On the Indian sub-continent the size of the populations involved, the mix of presence and non-presence countries (e.g. Pakistan), and the severe nature of the threat posed to neighboring countries by the very large epidemiological pool of infections in India, argue for some special, urgent inter-country programming there.

Such sub-regional offices would be managerially weak, because they would be so small. The possibility of collaborating with UNAIDS, or another multi- or bilateral agency with a similar regional interest and management capability might be considered in this case. This would achieve the required synergies of

explicitly draw linkages between the regional strategy and country strategies. For example, ANE may consider including in its R4 review guidance expectations that:

- The regional program undergo strategy and R4 reviews along with those undertaken by the Missions.
- Both the regional program and the Missions include in their strategy/R4 documents rationales for their selected HIV/AIDS activities, in light of the efforts of other (especially USAID) players in the region; and
- ANE take, as part of its strategic coordination role, the responsibility of ensuring that the overall Bureau investment in the HIV/AIDS area, including both the regional and the Mission strategies, reflect a coherent, defensible balance between country and regional activities to forward the Agency's Strategic Objective in HIV/AIDS.

At the operational level, enhancing the complementarity of Mission and regional strategies calls for the clarification of roles referred to above, plus encouragement of ongoing communications, particularly between the regional coordinator and the health officers in the Missions. The Bureau may find it appropriate to include actions to encourage and facilitate such communication among the responsibilities of the Regional HIV/AIDS Advisor.

Management of a Regional Program if there were no Regional Unit

If there were no regional unit in the field, ANE could fund programs that conform to current ANE AIDS Strategy, running some of them through international PVOs (those that implement through national NGOs and local CBOs) and some through UNAIDS (that involve implementation through, or direct links with, governments). A number of international PVOs are working in HIV/AIDS prevention in various ways in Asia: CARE, PATH, PACT, PSI, the Alliance. There are many country offices and some have regional offices that can coordinate country programs. There is some specialization among PVOs: PSI excels in CSM and IEC; PACT and the Alliance in local NGO strengthening, PATH in STD behavior research, reproductive health, and STD syndromic management. ANE's Washington burden would increase substantially, however, and many of the benefits of the effectiveness of management and expertise within the region (see above) would be lost. The Evaluation Team does not consider this a cost-effective or cost-beneficial alternative; indeed, it seriously calls into question the overall cost-benefit of a regional program.

The only remaining alternative would be to strengthen capacity to focus, strategically and operationally, on the region, within the HIV/AIDS Division of the G Bureau. The implications of this alternative are beyond the purview of this Evaluation.

Functions of USAID Staff Member based in Asia for ANE Regional Strategy Objective
To assist the Asia/Near East Bureau in program implementation, and strategic planning and analysis, with a special focus on the HIV/AIDS epidemic in Asia.
Responsibilities and Tasks:

- 1. Assist in the design, monitoring and implementation of HIV/AIDS programming in ANE, in accordance with the Bureau's HIV/AIDS Action Plan, and with Agency policy.
- a. Provide technical guidance in allocating bilateral, field support and regional funds to country and subregional programs in Asia.
- b. Monitor the implementation of the ANE Bureau regional HIV/AIDS program in Asia.

- c. Coordinate the evaluation of the ANE Bureau regional HIV/AIDS program in Asia.
- d. Liaise with other members of the ANE Bureau working on the HIV/AIDS regional program for (Asia and) the Near East.
- 2. Participate (as a member of the team) in whatever mechanism ANE identifies for implementing its regional HIV/AIDS program in Asia. Within this mechanism/team:
- a. Be primarily responsible for policy dialogue.
- b. Be primarily responsible for coordination with mission PHN staff, G and other Bureaux, other USG agencies and other donors (and in particular the Common Agenda with Japan).
- c. Coordinate monitoring and analysis of regional data, and program, intervention and research developments.
- d. Participate in providing technical assistance to ANE Missions in Asia in the design, implementation and evaluation of HIV/AIDS strategies, programs and bilateral projects.
- 3. Assist with other strategic planning and analysis exercises as assigned.

Annex 9

Itinerary

1996

September

1996

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1 2		4	5	6	
	3 9	10	п	Team Leader departs Delhi for London	London visit (Team Leader only)	Team Leader departs London for WDC
ı	Team Planning Meeting	Team Planning Meeting	Washington visits	Washington visits	Team departs WDC for Bangkok 12:50 p.m.	Team arrives in Bangkok
2	2 2: Bangkok●▶	14 Bangkok●▶	Bangkok®▶	Lv Bangkok/Arr Vietane (one person)	Lv Vietane & 27 Bangkok/Ar Phnom Penh Lv Bangkok/Ar Dhaka	
2	9 Leave Dhaka/Ar Kathmandu ▶				٠	

Team One

Team Two

1996

October

Cl	OU	er.	
		_	 _

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		Leave Phnom Penh/Ar Jakarta	2	3	4	Lv Jakarta/Ar Manila © Lv Kathmandu/ Ar Delhi 🕒
e	Manila — Delhi — Delhi	7 8	9	10	Lv Manila/Ar WDC • Lv Delhi/Ar WDC	12



1996

Annex 10

Contact List

94

Contact List

Name

Affiliation

Bangladesh

Richard Greene Zareen Khair

Najmus Shar Sadiq

Nazrul Islam M. Gulaiu Rasul

Yumiko Kashiba

Maj. Gen. M. R. Choudhury

Abu Jamil Faisel

Perveen Rasheed

Waliur Rahman

Monsur Ali

Shahnaz Shabnam

Lisa J. Messersmith

Deputy Director, Office of Population, USAID/Dhaka

Project Management Specialist, USAID/Dhaka

Program Officer, UNDP

Project Director, AIDS Prevention and Control Program National Consultant, AIDS Prevention and Control Project

Planning Department, JICA

Chairman, National AIDS Committee

Country Representative, Access to Voluntary and Safe

Contraception (AVSC) International

Project Manager, Social Marketing Company (SMC)

Managing Director, SMC

Deputy Project Director, Institute of Postgraduate Medicine and

Research, Dhaka (IPMRD)

Pathfinder International

Country Program Adviser, UNAIDS

Cambodia

Michele Moloney-Kitts Cheryl L. Urashima

Seng SutWantha

HPN Officer, USAID/Cambodia Country Representative, PACT

Coordinator Assistant, HIV/AIDS/STD Prevention and Control

Program

Enric Freixa Ouk Vong Vathiny

Dr. Hor Bun Leng Pawana Wienrawee

Medical Coordinator, Medicines Sans Frontiers Deputy Director, Family Health and Spacing Project

Chief, National AIDS Committee Country Program Advisor, UNAIDS

India

Linda Morse

Desaix Myers

John Rogosch Rekha Masilamani

Asheena Khulak-Dina M. Mahalingam

K. Loganathan S. Ramasundaram Luke Samson

Director, USAID/New Delhi

USAID/New Delhi USAID/New Delhi

Chief, Health Services Division, PHN, USAID/New Delhi Project Officer, Overseas Development Administration (U.K.)

Overseas Development Administration (U.K.) Institute for Social Education and Development

Project Director, Tamil Nadu State AIDS Control Society

Director (Programs), Sharan, New Delhi



Saraswathi Sankaran Deepam Educational Society for Health

Suniti Solomon Y.R.G. Gaitonde Medical, Educational and Research

Foundation

Mr. Ganesh Y.R.G. Gaitonde Medical, Educational and Research

Foundation

Jimmy Dorabjee Program Manager, Drug Demand Reduction Project, Sharan

Dr. Asha Rao Project Director, Bhoruka Public Welfare Trust

G. Kumaresan AIDSFACT

Dr. S.K. Satpathy Project Director, National AIDS Control Organization

Dr. Cherif Soliman WHO/FHI Consultant, STD Specialist Patrick Brenny Country Program Adviser, UNAIDS/India

Cornelia Davis Team Leader, UNAIDS
Thomas Philip Resident Advisor, AIDSCAP

Yasushi Noguchi Ministry of Foreign Affairs, New Delhi

B. Ramadeivi ROSHINI

Shasi Kyle HOPE World Wide, Madras Abraham James HOPE World Wide, Madras

P. Manorania CHES

P. Krisnamurthy Project Director, APAC-VHS, Madras

Shyanila Natrajan SIAPP, Madras

V. Sukuntha Program Officer, UNDP

Henrik Hansen UNDP
Jens Petersen JPO/UNFPA
Asa Anderson JPO/UNFPA
Sanjiv Kumar UNICEF

Alison King Inter-Agency Support Unit Officer, United Nations

Raj Kumar P&H Specialist, World Bank

Ashita Mittal UNDCP

Lelya Tegmo-Reddy Deputy Director, ILO

Katrine Danielsen JPO/ILO

Rajiv Chandran Senior Information Officer, UNIC

Ayami Noritake JPO/UNIFEM

Indonesia

Barbara Spaid Director, USAID/Jakarta

Leslie B. Curtin Chief, Population Division, USAID/Jakarta

Ratna Kurniawati USAID/Jakarta

Barbie Rasmussen Country Director, Project Concern International (PCI)

Dr. Cecilia Boediono PCI

Dr. H. Abdul Manaf

Director, Directorate of Direct Transmitted Disease Control

Nick G. Dharmaputra

Executive Officer, Humane Medicines, Center for Health

Research, University of Indonesia

Teguh Budiono DKT Indonesia Social Marketing Program

Nafsiah Mboi Member of Parliament

Drs. Dachroni

Anne W. Scott Country Director, PACT

Made Efo Suarmiartha

Yayasan Citra Usadha Indonesia (YCUI) Yufrizal Putra Executive Director, UTAMA Nancy Jamieson IEC/BCC Adviser, AIDSCAP Chief of Party, AIDSCAP Jane S. Wilson

Dr. George Loth

Country Program Advisor, UNAIDS

Centre for Health Education, MOH

Laos

Wendy Chamberlain

U.S. Ambassador Mike Carroll Director, CARE

Than Impeng CARE Nang Vong CARE Khanmany Sounthammavong CARE Prue Borthwick **CARE**

Sithat Sisiangmai Secretariat, NCAA Dr. Chantone Secretariat, NCAA

Provincial Committee for the Control of AIDS (PCCA) Pokham Detratsavong

Lao Women's Union Viengxay Nola Sirikhit Bupha Lao Women's Union Khampone Insisiengmai Lao Youth Union Khamkhian Sinmany Lao Red Cross

Chantailit Chiamsisulat Ministry of Culture and Information

Project Coordinator, HIV/AIDS Prevention and Control Project Tokujiro Kamigatakuchi

Country Program Advisor, UNAIDS Tony Lisle

Nepal

Technical Advisor, Office of Health and Family Planning, Barbara Winkler

USAID/Nepal

Pancha Kumari Manandhar Population Specialist, Office of Health and Family Planning,

USAID/Nepal

Chief, Office of Health and Family Planning, USAID/Nepal Molly Gingerich

Managing Director, Stimulus Advertisers Ravin S. Lama Second Secretary, Japanese Foreign Ministry Hidevuki Onishi

Binita Joshi Economic Cooperation Division, Japanese Foreign Ministry Director, National Center for AIDS & STD Control, Ministry of Dr. Prakash Aryal

Nepal Contraceptive Retail Sales Company **Binod Khatry**

Shiba Hari Maharjan Lifegiving and Lifesaving Society Manisha Singh Lifegiving and Lifesaving Society Dr. Bijaya Neupane Family Planning Association of Nepal

Nancy Russell Resident Advisor, CEDPA Joy Pollock Resident Advisor, AIDSCAP



Banamali Subedi Field Coordinator, General Welfare Pratisthan/AIDSCAP

Mahesh Bhattarai General Welfare Pratisthan/AIDSCAP Asha Basnyat Senior Program Officer, AIDSCAP

Siddarth Tuladar New Era

Mahesh Pradhan Nepal Chemists and Druggists Association

Philippines

Carol Carpenter-Yamen USAID/Manila Cora Manaloto USAID/Manila

Jacque Jeugmans Regional Technical Assistant, Asian Development Bank

Wayne Antkowiak Consultant, World Health Organization

Kyo Hanada Project Leader, Family Planning and Maternal Health Project,

JICA

Tokujiro Kamigatakuchi Project Coordinator, HIV/AIDS Prevention and Control Project,

JICA

Antonio S. Lopez Assistant Secretary, Department of Health, Office of Public

Health Sciences

Evelyn Grace Busa Gacad Executive Director, Philippines HIV/AIDS NGO Support

Program (PHANSuP)

Vicente S. Salas Program Manager, UNDP

Geoff Manthey Country Program Advisor, UNAIDS

Peter Resurrection Director of Communication Programs, ReachOut

Michael E. Valle Project Coordinator, Forge, Inc.

Edwin A. Sosas Community Health Outreach Worker, AIDS Surveillance

Education Project

Carmina Noela A. Aquino AIDS Surveillance and Education Project, PATH Sandra B. Tempongko Associate Professor, University of the Philippines

Marlyn Borromeo NASPCP
Rey Imperial CEMSHAD
Prof. Nymia Simbulan CEMSHAD
Butch Manalastas UP OB-GYN
Teodora Tiglao UPCPH

Ilya Abellanosa City Health Department, Cebu City Dr. Fernandez City Health Department, Cebu City

Verginia Mesola Cebu City

Antonio S. Lopez Department of Health

Thailand

Julie Klement USAID/Bangkok

Robert Bennoun Project Officer-HIV/AIDS, UNICEF Alessio Panza Coordinator, EC AIDS Programme

Gary Suwannarat Assistant Representative, The Ford Foundation

Cappia Taqueban Deputy Director, Asia-Pacific Development Communication

Center, Dhurakijpundit University

Lertlak S. Burusphat Vice Rector for Administrative Affairs, Dhurakijpundit

University

Margery Lazarus Medical Anthropologist, Social Research Institute, Chiang Mai

University

Aurorita M. Mendoza Regional Representative, Program for Appropriate Technology

in Health (PATH)

Chumpon Apisuk Naam Chewit Concrete House

Waranya Teokul National Economic and Social Development Board
Rachel Sacks Population and Community Development Association

Tim Brown Fellow, East-West Center

Prayong Phawaphutanond Manager, Population and Community Development Association

Rachael Sacks HIV/AIDS Planning Officer, Population and Community

Development Association

Scott Bamber Project Development Specialist, Thai-Australia Northern AIDS

Prevention and Care Program (NAPAC)

Neil Brenden Director, Asia Regional Office, AIDSCAP

Steve Mills Evaluation Officer, AIDSCAP

Tony Bennett Senior Program Officer, Asia Regional Office, AIDSCAP

Kari Hartwig Program Officer, AIDSCAP

Chalintorn Burian AIDSCAP

Heather Dornoch Second Secretary, AusAID Tony Coghlan First Secretary, AusAID

Werasit Sittitrai Coordinator, Department of Policy, Strategy and Research,

UNAIDS

Jean-Louis Lamboray Team Leader, UNAIDS

Judy RudlandIntercountry Technical Adviser, UNAIDSTim FranceInformation Support Manager, UNAIDS

Washington, D.C.

Sumali Ray-Ross Program Specialist, Asia Region, ACCESS Project, CEDPA

Sara Siff University Research Corporation & Center for Human Services

Molly Reilly Assistant Director, Women in Politics Program, The Asia

Foundation

Kim Hunter Program Officer, Women in Politics Program, The Asia

Foundation

Carol Becker Division Chief, ANE/SEA/SPA, USAID/W

Carol Rice Public Health Advisor, ANE/SEA/SPA, USAID/W

Irene Koek PPC/PHD, USAID/W

Christopher McDermott ANE/SEA/SPA, USAID/W

David Oot Director, G/PHN/HN, USAID/W

Victor Barnes Acting Division Chief

Paul Delay G/PHN/HN/HIV-AIDS, USAID/W Karen Morita G/PHN/HN/HIV-AIDS, USAID/W

Keys MacManus

Alex Ross

Hirokazu Anada

Harumi Kitbayashi

Judith Fourtney

Gail Goodridge

Steven S. Forsythe

Leslye D. Boban

G/PHN/OFPS, USAID/W

AFR/SD, USAID/W

Deputy Resident Representative in the USA, JICA

Deputy Director, Research and Development Division, Institute

for International Cooperation, JICA

Corporate Director for Scientific Affairs, AIDSCAP

Associate Director, Office of Country Programs, AIDSCAP

Health Economics Officer, AIDSCAP

Program Officer/ASIA&LA/C/OCP, AIDSCAP